Dear Provider:

Please allow us to extend a personal greeting in welcoming you to Simply Healthcare Plans. Attached you will find your Simply Healthcare Plans, Inc. (SHP) Provider Handbook that has been written to specifically meet the requirements to administer the Plan’s products, services, policies and procedures and to supplement the provider agreement.

Simply Healthcare Plans is a health maintenance organization (HMO) that has a contract with the the Center for Medicare and Medicaid Services (CMS) to provide the health needs of Medicare beneficiaries enrolled with our plan.

Medicare is a health insurance program for people age 65 or older, under age 65 with certain disabilities, and all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

SHP offers an appropriate and accessible range of preventive, primary care, and specialty services to meet the needs of its Medicare enrollees, and maintains a sufficient number, mix and geographic distribution of providers. It is a prepaid, comprehensive system of health care delivery.

We have designed this handbook to assist you in the processes that include your responsibilities as a Primary Care Physician (PCP), as a specialist or vendor, as well as protocols for prior authorization and referrals, medical necessity standards and practice protocols, including guidelines that address treatment of chronic and complex conditions, covered and emergency services, claims and encounter submissions, member rights and responsibilities and many other important functions and information. It is all outlined for you in the Table of Contents.

There are times when updates to this handbook may be required, due to regulatory changes or internal policy revisions/updates. When this occurs we will advise you if it is a new (add) or revised (replace) change - you will simply have to add or replace the specific information in the handbook.

You may request additional copies of the Handbook at no charge from your Provider Relations representative. The Handbook is also available in our website at www.simplyhealthcareplans.com, under the Medicare section.

Thank you for actively participating in the delivery of quality health care services to our members. We encourage you to contact us if you have any suggestions for improving the services that we provide.

Sincerely,

Simply Healthcare Plans, Inc.
Simply Healthcare Plans Mission Statement

To strive to improve the quality of life and health care of our members through our commitment to member satisfaction, professional excellence and service to our members in a caring and compliant manner.
SIMPLY HEALTHCARE PLANS – PROVIDER HANDBOOK

Table of Contents

Introduction .............................................................................................................................................. 2
Mission Statement ................................................................................................................................. 3

Section 1: Important Plan Contact Information ......................................................................................... 7
  Responsibilities of Health Plan ........................................................................................................... 8
  Contract Requirement through Policies, Standards and Manuals ......................................................... 8

Section 2: Member Enrollment, Eligibility and Disenrollment ................................................................. 9
  Member Eligibility and Enrollment ..................................................................................................... 9
  Effective Date of Enrollment .............................................................................................................. 9
  Member Eligibility ............................................................................................................................. 9
  Inpatient Hospital Services ................................................................................................................ 10
  Simply Healthcare Plans Member Identification Card ...................................................................... 10
  CMS Enrollment Period .................................................................................................................. 11
  Simply’s Medicare Advantage Plans ............................................................................................... 12

Section 3: Marketing Guide ..................................................................................................................... 13-16

Section 4: Provider Responsibilities .......................................................................................................... 17
  Non-discrimination ............................................................................................................................. 17
  Access to Care .................................................................................................................................. 17
  Support from SHP ............................................................................................................................. 17
  Community Outreach ....................................................................................................................... 17
  Primary Care Physician (PCP) Responsibilities .............................................................................. 18
  Adult Health Screening ..................................................................................................................... 18
  Domestic Violence and Abuse Screening ......................................................................................... 19
  Smoking Cessation ........................................................................................................................... 19
  Members with Special Healthcare Needs ........................................................................................ 20
  Living Will and Advance Directives ................................................................................................. 20
  After-Hours, Weekends and Holiday Services .............................................................................. 20
  PCP Coverage .................................................................................................................................. 21
  Physician Panel Changes .................................................................................................................. 21
  PCP’s Request to Disenroll a Member from their Panel ................................................................... 21
  Family Planning ............................................................................................................................... 21
  Diagnosis and Treatment of Tuberculosis ....................................................................................... 22
  Interdisciplinary Care Team Meetings ............................................................................................. 22
  Responsibilities of All Providers ...................................................................................................... 22-23
  Health Care Extenders (ARNPs and Pas) ......................................................................................... 23
  Additional Specialist Responsibilities ............................................................................................... 24
  Member Information and Confidentiality ......................................................................................... 24
  Changes in Provider Information ...................................................................................................... 25
  Provider Termination ....................................................................................................................... 25
  Provider-Required Incident Reporting ............................................................................................. 25
  Delegated Providers ......................................................................................................................... 26
  Medicare Risk Adjustment (MRA) ..................................................................................................... 26-27
Section 4: Utilization Management Department

Notifications and Referrals: Quick Authorization Form and Prior Authorization ........................................28-31
Emergency Services .................................................................................................................................31
Post-stabilization Care ............................................................................................................................32
Hospital In-patient Services ....................................................................................................................33
In-patient Hospital Care Limits ...............................................................................................................33
Non-Routine Dental Care Covered Under Outpatient Services ............................................................33
Hospice ..................................................................................................................................................33-34
Observation Services ...............................................................................................................................35
Out-of-Network Requests for Non-emergency Services ........................................................................35
County Health Departments (CHD) ........................................................................................................35
Mental Health ........................................................................................................................................35-36
Requests for Second Medical Opinions ..................................................................................................36
Referrals for Members with Chronic Conditions ...................................................................................36
Continuity and Transition of Care Needs .................................................................................................36
Post Discharge Planning/Transition of Care ............................................................................................36-37
Care Management Services ..................................................................................................................37
Utilization and Medical Criteria Resources ............................................................................................37-38
Adverse Determinations ..........................................................................................................................38

Section 6: Covered Services ................................................................................................................39
Covered Services Summary ......................................................................................................................39-41

Section 7: Members Rights and Responsibilities ..................................................................................42
Summary of Members Rights and Responsibilities ..................................................................................42
Advance Directives ..................................................................................................................................43

Section 8: Preventative Care and Clinical Practice Guidelines ..............................................................45
Links to Guidelines .................................................................................................................................45-47

Section 9: Medical Records Standards ................................................................................................48
Requirements ...........................................................................................................................................48-50
Medical Records Audits and Compliance ...............................................................................................50

Section 10: Quality Improvement .........................................................................................................51
Program Goals ..........................................................................................................................................51
Care Management and Prevention/Wellness Programs .........................................................................51
Resources: on Tobacco and Substance Abuse, Domestic Violence .........................................................52
Providers Right to Corrective Action, Fair Hearing and Reporting to Regulators ....................................52
Medicare Advantage Plan Star Ratings ....................................................................................................53
HEDIS .....................................................................................................................................................53
CAHPS ....................................................................................................................................................53-54

Section 11: Cultural Competency Program ..........................................................................................55
Overview, Standards, Program Goals and Components ........................................................................55-56

Section 12: Credentialing .......................................................................................................................57
Overview and Required Information .......................................................................................................57
Site Reviews ............................................................................................................................................57
Credentialing Review Committee ..........................................................................................................57
Verification Process .................................................................................................................................57
Re-credentialing .......................................................................................................................................58
Medicare Program .................................................................................................................................58
Provider's Right to Review, Notify and Correct Information ...........................................58
Provider's Right to be Informed ..................................................................................58

Section 13: Participating Provider Complaints ................................................................59

Section 14: Member Grievances and Appeals ...............................................................60-63
   Definitions .............................................................................................................60
   Formal Grievance Process ....................................................................................61
   Medicare Reconsideration (Appeal) ......................................................................62

Section 15: Claims .......................................................................................................64
   Overview ..............................................................................................................64
   Claims Submission ..............................................................................................64
   Filing Electronically ............................................................................................65
   Timely Claim Submission ....................................................................................65
   Clean Claim .........................................................................................................65
   Timely Claims Processing and Payment .............................................................65
   Claims for Emergency Services .........................................................................65
   Coordination of Benefits ....................................................................................66
   Third Party Liability ............................................................................................66
   Retroactive Eligibility Changes ........................................................................66

Section 16: Compliance & Fraud, Waste and Abuse ......................................................67
   HIPPA ................................................................................................................68

Section 17: Special Needs Plans and the Model of Care ..............................................69-70

Section 18: Forms .......................................................................................................71
   1. Referral and Authorization Form .....................................................................72
   2. Quick Authorization Form .............................................................................73
   3. Concordia Referral Form .............................................................................74
   4. Incident Report Form .....................................................................................74
   5. PCP Initiated Transfer Request Form .............................................................75
   6. Practitioner Disease Report Form ....................................................................76

Section 19: Infection Control and Prevention Plan ......................................................77-79

Section 20: Safety and Health Program .....................................................................80-83
## SECTION 1
**IMPORTANT SIMPLY HEALTHCARE PLANS CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>CONTACT INFORMATION</th>
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| Provider Relations Department  | 804 Douglas Road, Suite 500  
Coral Gables, Florida 33134-4414  
Phone: 1-800-887-6888 ext. 6005  
Fax number: 305-408-5765                                                |
| Member Services Department     | 1701 Ponce De Leon Blvd, Suite 300  
Coral Gables, Florida 33134-4414  
Phone: 1-800-213-1133  
Fax number: 305-408-5880                                               |
| Utilization Management:        | 1701 Ponce De Leon Blvd, Suite 300  
Coral Gables, Florida 33134-4414  
Phone: 1-800-887-6888 ext. 2271  
Fax number: 1-800-283-2117                                               |
| Referrals/Pre-Certification Special Information:                          |                                                                                     |
| All medically necessary STAT/URGENT or Expedited Requests should be called to the Pre-Certification telephone queue and identified as such. |                                                                                     |
| Please provide all documentation for medical necessity determination available when making a request |                                                                                     |
| Care Management Services       | 1701 Ponce De Leon Blvd, Suite 300  
Coral Gables, Florida 33134-4414  
Phone: 1-855-431-1606  
Fax number: 786-441-4607 or 877-577-0117                                   |
| Utilization Management:        | 1701 Ponce De Leon Blvd, Suite 300  
Coral Gables, Florida 33134-4414  
Phone: (800) 887-6888, ext. 2271  
Auth Request Fax number: 1-800-283-2117  
Clinical Information Fax number: 305-408-5882                                 |
| Inpatient Services             |                                                                                     |
| Pharmacy Department            | 1701 Ponce De Leon Blvd, Suite 300  
Coral Gables, Florida 33134-4414  
Phone: 1-800-887-6888 ext. 5792  
Fax number: 305-408-5883 or 1-877-577-9045                                   |
| Claims Department              | Simply Healthcare Plans, Inc.  
Attn: Claims  
PO BOX 21535  
Eagan, MN 55121  
Phone: 1-800-887-6888 ext. 2166                                               |
| Behavioral Health Services     | Concordia  www.Concordia.com  
10200 Sunset Drive, Miami, FL 33173  
Phone: 877-698-7787 Fax number: 305-514-5321                                    |
| Transportation                 | TMS – 866-411-8914                                                                  |
| Hearing                       | HearUSA - 800-528-3277                                                               |
| DME                           | AllMed Services  
For Authorizations call SHP: 800-887-6888-2271                                 |
<table>
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<th>Service</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Dental Services for Adults</td>
<td>DentaQuest 1-877-468-5581</td>
</tr>
<tr>
<td>Ophthalmology Services</td>
<td>Premier Eye Care&lt;br&gt;Phone number for PCPs to call for Authorizations: 1-800-738-1889</td>
</tr>
<tr>
<td>Optometry Services</td>
<td>Florida Eye Care Associates: 1-877-481-3322</td>
</tr>
<tr>
<td>Grievance &amp; Appeals Department</td>
<td>1701 Ponce De Leon Blvd&lt;br&gt;Coral Gables, Florida 33134 &lt;br&gt;Phone: 1-877-577-0115 &lt;br&gt;Fax number: 305-408-5880</td>
</tr>
<tr>
<td>Credentialing Department</td>
<td>1701 Ponce De Leon Blvd, Suite 300&lt;br&gt;Coral Gables, Florida 33134-4414 &lt;br&gt;Phone: 1-800-887-6888 ext. 5734 &lt;br&gt;Fax number: 305-408-5887</td>
</tr>
<tr>
<td>Compliance Officer</td>
<td>1701 Ponce De Leon Blvd, Suite 300&lt;br&gt;Coral Gables, Florida 33134-4414 &lt;br&gt;Phone: 1-877-253-9251 &lt;br&gt;Fax number: 305-408-5858</td>
</tr>
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Responsibilities of Health Plan – Reference **Policy # ADM001**

Contract Requirement through Policies, Standards and Manuals – Reference **Policy#: PR002-SHP**
SECTION 2

MEMBER ENROLLMENT, ELIGIBILITY, AND DISENROLMENT

Member Eligibility and Enrollment

Medicare beneficiaries are eligible to enroll in an HMO if they are entitled to Medicare Part A and enrolled in Part B.

Member Eligibility

SHP’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 SHP website at www.simplyhealthcareplans.com, under “Providers” login to our Provider Portal and request eligibility information.
- Contact the SHP Member Services Department at 1-800-213-1133

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.

Ineligible for Membership

The following categories of recipients who are ineligible for membership:
- Individuals who are medically determined to have ESRD prior to completing the health plan enrollment election.
- Individuals enrolled in a Medicare PDP (Prescription Drug Plan) cannot be simultaneously enrolled in an MA-PD (Medicare Advantage and Prescription Drugs plan.
- Individuals residing outside of the health plan’s service area.
- Individuals who do not agree to abide by the rules of the plan.
- Individuals not enrolled with both Medicare Part A & Part B.
- Individuals who are not legal United States residents.

Assignment of Primary Care Physician

Each member selects a Primary Care Physician (PCP) upon enrollment. The PCP functions as a “gatekeeper” arranging for all of the member’s healthcare needs for primary, specialty and ancillary services by promoting quality and continuity of care.

Member Listing

The PCP office will receive a monthly active member listing by the end of the first week of each month. The list consists of those Simply Medicare members who have chosen the PCP office to provide them with PCP services. Please verify that all Medicare patients receiving treatment in your office are on your membership listing. If you do not receive your list by the date mentioned above, please contact your assigned Provider Service Executive. If there are any questions regarding a patient’s eligibility, please contact Simply’s Provider Operations Department at the number in the Key Contact List.
Inpatient Hospital Services

Inpatient hospital services include all items and medically necessary services which provide appropriate care during a stay in a participating hospital. These services include room and board, nursing care, medical supplies, and all diagnostic and therapeutic services. Simply Healthcare Plans shall be responsible for Part A inpatient care to members who at the time of disenrollment are under inpatient care until the time of his/her discharge.

Simply Healthcare Plans shall not be responsible for coverage of Part A inpatient services for inpatient care already being provided at the time of enrollment of a member. The hospital would have to bill either the member insurance carrier prior to Simply Healthcare Plans or Medicare directly.

Simply Healthcare Plans Member Identification Card

Member identification cards are intended to identify plan members and facilitate their interactions with physicians and other health care providers. Information found on the member identification card may include the member’s name, identification number, Primary Care Physician’s name and telephone number, co-payment information, 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.

Please refer to SAMPLE Simply Healthcare Plans Member Identification Card:
Enrollment Options for Medicare beneficiaries:

- Enroll in a Medicare Advantage Plan that has prescription drug coverage (MAPD);
- Enroll in a stand alone Prescription Drug Plan (PDP) for the prescription drug coverage, and receive health care coverage from traditional Medicare;
- Enroll in a Medicare Advantage Plan that doesn’t have prescription drug coverage.

There are Five types of Election Periods during which individuals may make enrollment changes for MA plans:

1. The Annual Election Period (AEP);
2. The Initial Coverage Election Period (ICEP);
3. The Open Enrollment Period for Institutionalized Individuals (OEPI);
4. All Special Election Periods (SEP); and
5. The Medicare Advantage Disenrollment Period (MADP)

People who are new to Medicare have an Initial Coverage Election Period (ICEP) that is similar to the Initial Enrollment Period for Part B. This period begins three (3) months immediately before the individual’s first entitlement to both Medicare Part A and Part B and ends on the later of 1) the last day of the month preceding entitlement to both Part A and Part B, or 2) The last day of the individual’s Part B initial enrollment period. The AEP is from October 15th through December 7th of each year. During the AEP the member may enroll or disenroll from an MA plan. Changes made would take effect January 1st of the following year. The MADP is from January 1st through February 14th of every year. During the MADP, MA plan enrollees may prospectively disenroll from any MA plan and return to Original Medicare.

Special Enrollment Periods (SEP)

- Change in Residence
- MA contract violation, MA Non-renewal or Terminations
- SEPs for Exceptional Conditions, Employer/Group Health Plan
- Individuals who disenroll if CMS sanctions an MA plan
- Individuals enrolled in Cost Plans that are Non-renewing their contracts
- Individuals in the Program of All-Inclusive Care for the Elderly (PACE)
- Dual-Eligible individual(s) or individuals who lose their dual-eligibility
- Individuals who dropped a Medigap Policy when they are enrolled for the first time in an MA plan, and who are still in a “trial period”
- Individuals with ESRD whose entitlement determination is made retroactively
- Individuals whose Medicare entitlement determination is made retroactively
- MA SEPs to Coordinate with Part D Enrollment Periods
- Individuals who have an involuntary loss of creditable coverage, not including a loss due to failure to pay plan premiums
- Individuals who lose Special Needs Status
- Individuals who belong to a Qualified State Pharmaceutical Assistance Program (SPAP) or lose SPAP eligibility
- Non-Dual Eligible Individuals with LIS (Low Income Subsidy) and Individuals who lose LIS
- Enrollment into a Chronic Care SNP (Special Needs Plan) and Individuals Found Ineligible for a Chronic Care SNP
- Disenrollment from Part D to Enroll in or Maintain other Creditable Coverage
- Enrollment in an MA plan or PDP with a Plan Performance Rating of five (5) stars
- SEPs for Beneficiaries Age 65
- Individuals entering, residing or leaving a long term care facility

Note: Unless they show proof of “credible coverage”, people with Medicare who do not enroll in a drug plan when they are first eligible will likely have to pay a penalty if they choose to enroll in a drug plan later.
Simply’s Medicare Advantage Plans

- **Simply More**: The traditional Medicare Advantage Plan that offers a comprehensive array of benefits specially designed to fit your healthcare needs

- **Simply Extra**: Our Premium Give-Back plan offers benefits and services above traditional Medicare with a Part B premium reduction of up to $96.40

- **Simply Options**: Our Point-of-Service plan that offers benefits and services above traditional Medicare with an out-of-network benefit and a Part B premium reduction of up to $75.

- **Simply Complete**: It is our Dual Special Needs Plan (D-SNP), a specialized Medicare plan which benefits are designed for people with special healthcare needs. The members must have Medicare and Medicaid. The care and coordination of care for these members is guided through the Model of Care of this Plan; our care managers assist the members obtaining benefits from both sources.

- **Simply Comfort**: It is our Institutional Equivalent Special Needs Plan, (IE-SNP) for eligible individuals living in the community who require and institutional level of care based on the State of Florida’s CARES assessment. This type of Special Needs Plans may restrict enrollment to individuals who reside in an ALF (Adult Living Facility) if necessary, to ensure uniform delivery of specialized care. The care and coordination of care for these members is guided through the Model of Care of this Plan. If you are a provider for this plan, you have or will receive training on the IE-SNP Model of Care.

- **Simply Care**: It is an institutional SNP for eligible individuals designed for people who live in an institution or who need a level of care that is usually provided in a nursing home. Its benefits are designed for people with special healthcare needs. The care and coordination of care for these members is guided through the Model of Care of this Plan.

  Please note that benefits vary in each different plan.
SECTION 3

Marketing Guide

Specific Guidance about Provider Promotional Activities – Refer to the Chapter 3: Medicare Marketing Guidelines, §70.12 to §70.12.7 for more detailed information.

As used in specific guidance about provider activities, the term “provider” refers to all providers contracted with Simply Health Plans, Inc. (Simply) and their sub-contractors, including but not limited to: pharmacists, pharmacies, physicians, hospitals, and long term care facilities. Simply shall ensure that any provider contracted with the plan (and its sub-contractors) performing functions on the plan sponsor’s behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agrees to the same restrictions and conditions that apply to Simply through its contract, and shall prohibit them from steering, or attempting to steer an undecided potential enrollee toward a plan, or limited number of providers, offered either by Simply or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents). While conducting a health screening providers may not distribute plan information to patients.

CMS is concerned with the provider activities for the following reasons:
Providers may not be fully aware of all plan benefits and costs; and
Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan vs. acting as the beneficiary’s provider.

Providers may face conflicting incentives when acting as a plan representative. For example, some providers may gain financially from a beneficiary’s selection of one plan over another plan. Additionally, providers generally know their patients’ health status. The potential for financial gain by the provider steering a beneficiary’s selection of a plan could result in recommendations that do not address all of the concerns or needs of a potential enrollee. These provider Marketing Guidelines are designed to guide plans and providers in assisting beneficiaries with plan selection, while at the same time striking a balance to ensure that provider assistance results in plan selection that is always in the best interests of the beneficiary.

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their health care options.

Following are requirements associated with provider activities. The plan sponsor shall ensure that any provider contracted with the plan (and its subcontractors) complies with these requirements:

1. Provider Activities and Materials in the Health Care Setting – Beneficiaries often look to their health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, eligibility requirements for Special Needs Plans). To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary’s needs and potential plan options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patient seek information or advice from their provider regarding their Medicare options. Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships (including PDP enrollment applications, but not MA or MA-PD enrollment applications). However, providers cannot accept enrollment applications.

Providers also cannot direct, urge or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their...
Providers may inform prospective enrollees where they may obtain information on the full range of plan options. Because providers are usually not fully aware of all Medicare plan benefits and costs, they are advised to additionally refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, http://www.medicare.gov, or 1-800-MEDICARE. The “Medicare and You” Handbook or “Medicare Compare Options” (from http://www.Medicare.gov), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plans should advise contracted providers of the provisions of these rules.

2. Plan Activities and Materials in the Health Care Setting – While providers are prohibited from accepting enrollment applications in the health care setting, plans or plan agents may conduct sales activities in health care settings as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. 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 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. Plans are prohibited from conducting sales presentations, distributing and accepting enrollment applications and soliciting Medicare beneficiaries 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, pharmacy counter areas and dialysis center treatment areas (where patients interact with their clinical team and receive treatment).

The prohibition against conducting marketing activities also applies to activities planned in these settings outside of normal business hours. An example of such activity includes providers sending out authorization to their members, such as nursing home members, to request that the member give permission for a plan sponsor to contact them about available plan products (through mailing, hand delivery or attached to an affiliation notice).

Only upon request by the beneficiary are plan sponsors permitted to schedule appointments with beneficiaries residing in long-term care facilities. Providers are permitted to make available and/or distribute plan marketing materials as long as the provider and/or facilities distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials they should do so knowing it must accept future requests from other plan sponsors with which it participates. Providers are also permitted to display posters or other materials in common areas within the long-term care facility and in admission packets announcing all plan contractual relationships. Long-term care facility staff are permitted to provide residents that meet the I-SNP (Institutional Special Needs Plan) criteria an explanatory brochure for each I-SNP with which the facility contracts. The brochure may explain about the qualification criteria and the benefits of being an I-SNP. The brochure may have a reply card or telephone number for the resident or responsible party to call to agree to a meeting or request additional information.

3. Provider Affiliation Information – Providers may announce new affiliations and repeat affiliation announcements for specific plans through general advertising (e.g., radio, television). New affiliation announcements are those providers who have entered into a new contractual relationship with Simply. Providers may make new affiliation announcements within the first 30 days of the new contract agreement. An announcement to patients of a new affiliation which names only one plan may occur only once 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 all
plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has an affiliation with certain plan sponsors and that only list plan names and/or contact information does not require CMS approval. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates.

4. SNP Provider Affiliation Information – Providers may feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider’s affiliation or arrangement by placing the SNP affiliations at the beginning of the announcement and include specific information about the SNP. This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated.

5. Comparative and Descriptive Plan Information – Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of all of the different plans with which they contract. Materials may not “rank order” or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution (e.g., these items are not subject to File & Use). The plans must determine a lead plan to coordinate submission of these materials. CMS holds plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers.

6. Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service Providing Third-Party – Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party (e.g., SHIPs, State agency or independent research organizations that conduct studies). For more information on non-benefit/service providing third party providers (See § 40.14.6, “Non-Benefit/Service-Providing Third Party Marketing Materials” of the Medicare Marketing Guidelines – Chapter 3)

7. Providers/Provider Group Web Sites – Provider websites may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center (OEC). NOTE: SNPs have the option to use the links, and the SNP should notify the provider that they may use the OEC link if they choose to but it is not required.

8. Leads from Providers – Plans and providers are responsible for following all Federal and State laws regarding confidentiality and disclosure of patient information to plan sponsors for marketing purposes. This obligation includes compliance with the provisions of the HIPAA privacy rule and its specific rules regarding uses and disclosures of beneficiary information. In addition, plans are subject to sanction for engaging in any practice that may reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services (i.e., health screening or “cherry picking”).

NOTE: A provider should not attempt to switch or steer plan enrollees or potential plan enrollees to a specific plan or group of plans to further the financial or other interests of the provider. All payments that plans make to providers for services must be fair market value, consistent for necessary services, and otherwise comply with all relevant laws and regulations, including the Federal and any State anti-kickback statute. For enrollment and disenrollment issues related to beneficiaries residing in long-term care facilities (e.g., enrollment period for beneficiaries residing in long-term care facilities and use of personal representatives in completing an enrollment application) please refer to Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual.
Sample Can/Cannot List for Provider Interactions with Potential Plan Enrollees:

Providers contracted with plans (and their subcontractors) can:

- Provide the names of health plans with which they contract and/or participate (See “Provider Affiliation Information” for additional information on affiliation).
- Provide information and assistance in applying for the Low Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as the providers offer the option of making available and/or distributing marketing materials to all plans with which they participate.
- Provide objective information on plan sponsors’ specific drug formularies, based on a particular patient’s medications and health care needs.
- Provide objective information regarding sponsors’ plans, including information such as covered benefits, cost sharing, and utilization management tools.
- Make available and/or distribute PDP enrollment applications, but no MA or MA-PD enrollment applications, for all plans with which the provider participates.
- Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Offices, CMS’s Web site at http://www.medicare.gov/, or calling 1-800-MEDICARE.
- Print out and share information with patients from CMS’s Web site.

Providers contracted with plans (and their contractors) cannot:

- Direct, urge, or attempt to persuade, any prospective enrollee to enroll in a particular plan or to insure with a particular company based on financial or any other interest of the provider (or subcontractor).
- Mail marketing materials on behalf of plan sponsors.
- Accept/collect enrollment applications.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health screenings is a prohibited marketing activity.
- Offer anything of value to induce plan enrollees to select them as their provider.
- Expect compensation in consideration for the enrollment of a beneficiary.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Offer sales/appointment forms.
- Distribute materials/applications within an exam room setting.
SECTION 4

PROVIDER RESPONSIBILITIES

Overview

This section of the Provider Handbook addresses the responsibilities of Simply Healthcare Plans, Inc. (SHP) 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, 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

SHP is committed to ensure that members are provided timely access to care. Access standards are noted below, to ensure that that all health care services are provided in a consistent, timely manner. The Primary Care Physician (PCP) or designated covering health care 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.

<table>
<thead>
<tr>
<th>SHP Appointment Access to Care Standards</th>
<th>Access Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Care Visit</td>
<td>Within one (1) month of the initial request</td>
</tr>
<tr>
<td>Routine Sick Care</td>
<td>Within one (1) week of the initial request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within one (1 ) day of the initial request</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Available by telephone 24/7/365</td>
</tr>
<tr>
<td>Office Waiting Time</td>
<td>Should not exceed thirty (30) minutes</td>
</tr>
</tbody>
</table>

Support from SHP to the PCP Offices

SHP will provide support to its 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 health care 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 Simply Healthcare Plans members:

- Ensure 24/7/365 availability as outlined in the Access to Care section noted above
- Identify, coordinate, and supervise the delivery and transition of care needs/services to each SHP 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) health care providers, as follows:
  - One (1) FTE physician per 1,500 Simply members
  - One (1) Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) for every 750 Simply 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
- Practice according to nationally recognized, evidence-based guidelines. Links to some guidelines are provided elsewhere on this Handbook
- Have a procedure for non-compliant members: medical record documentation of 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
- 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® (Health Care Effectiveness Data and Information Set) service
- Submit encounters on a CMS 1500 Form

Adult Health Screening

An adult health screening should be performed to assess the health status of all SHP members twenty-one (21) years of age or older. The adult member should receive an appropriate assessment and interventions, as indicated or upon request.

Providers are encouraged to review valuable Vaccines & Immunizations information on the Department of Health and Human Services, Center for Disease Control and Preventions website, which provides recommended vaccines and schedules for adults at: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html#laminated

The screening should also include: 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.
**Immunizations**

Covered Medicare Part B services include:
- Pneumonia vaccine
- Flu shots, once a year in the fall or winter
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
- Other vaccines if you are at risk and they meet Medicare Part B coverage rules

We also cover some vaccines under our Part D prescription drug benefit.

**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:

- **Abuse Hot Line**: To report suspected abuse, neglect or exploitation of elderly or disabled adults, call the toll-free number for the Florida Abuse Hotline (800) 96-ABUSE (962-2873) or TDD (800) 453-5145 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, Concordia at 877-698-7787
  - You may also contact the Utilization Management Department and ask to speak with a Nurse Case Manager;
  - **Alcoholic Anonymous** - In Dade: 305-461-2425, www.aammiamidade.org; Hillsborough and East Pasco: (813) 933-9123; Email: aainfo@aatampa-area.org

**Smoking Cessation**

Physicians provide an important role in helping members make decisions about their health care. The Plan offers a smoking cessation program that will help members break both the physical and psychological addiction to cigarettes.

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 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 SHP. Additionally, the Plan can assist OB providers when they identify pregnant members who are at risk as a result of smoking.

Providers are encouraged to review valuable information and educational materials available through the following Websites:

Members may also call **Florida Quit for Life** at 1-877-822-6669 for information on classes and resources to quit smoking.
Members with Special Health Care Needs

The Primary Care Physician (PCP) is essential for identifying members with special needs. These members are defined as persons 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 complex medical problems
- 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 or facility care

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

- Assess the member and develop a care plan
- Coordinate, review and update the plan of care with the member/legal representative or caregiver and the SHP’s Care Management team
- Identify and coordinate all transition of care needs, including direct access through standing referrals or approved visits, as indicated for the member’s health care needs
- Coordinate services with other health care 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

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 provider’s 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.

Also refer to the Advanced Directives subsection in Section 7, 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.
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.

Physician Panel Changes

If a PCP decides to close his/her panel to new members or to accept transferring of SHP members, the PCP must complete the following steps:

- Submit a written request to SHP providing at least sixty (60) calendar days prior to the effective date of closing his/her panel
- Maintain his/her panel open to all SHP members who were provided services prior to the closing of his/her panel
- When a re-open date is determined, the he/she will submit written notice to SHP 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, SHP reserves the right to close the PCP’s panel if the PCP has more than 1,500 members assigned 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 SHP members while having their panel open to other Medicare 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 health care 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 SHP in writing of the problem, with detailed supporting written documentation. The PCP will continue to provide medical care to the SHP 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. SHP and CMS 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 SHP 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 SHP Member Services number on the back of their SHP ID card.

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 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 SHP to ensure that members with special needs have an ongoing primary care giver responsible for coordinating the health care services provided to the member; this may be the PCP or, if indicated, a participating specialist
- Be responsive and cooperate with Simply’s Care Managers, who may contact the provider to share information and coordinate the care of members
- For members of Simply’s Special Needs Plans, the providers must participate in the Interdisciplinary Care Team meetings, usually conducted telephonically.
- Refer to a participating Plan specialist or other health care 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 by the health plan 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 SHP requests for medical records in order to comply with regulatory requirements.

Always inform SHP 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 SHP 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 SHP member, subscriber, or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a “fee-for-service” basis. 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 CMS and the Florida Attorney General, any and all administrative, financial and medical records and data relating to the delivery of items and services to SHP 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 SHP’s Compliance Officer at 1-877-253-9251. More information on Section 15.

Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (Health Care Effectiveness Data and Information Set) service.

Submit encounters on a CMS 1500 form to the plan’s claims department.

**Physician Use of Health Care 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 health care services to members within the scope or practice established by the rules and regulations of the State of Florida and SHP guidelines.

The physician will:

- Assume responsibility, to the extent of the law, when supervising ARNP’s and PA’s.
- Inform SHP 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 health care professional providing care is a physician.

Provide treatment for any member that is in need of health care 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 SHP 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.

**Additional Specialist Responsibilities**

- Specialists are responsible for treating SHP members referred to them by the PCP and communicating with the PCP and/or SHP’s Utilization Management Pre-Certification Department for authorization requests.
- Be responsive and cooperate with Simply’s Care Managers, who may contact the provider to share information and coordinate the care of members.
- For members of Simply’s Special Needs Plans, the providers must participate in the Interdisciplinary Care Team meetings, usually conducted telephonically.
- 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.

All health care 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 health care 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 health care provider permission to release his or her medical records to SHP, 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) – 60 days notice
- Group name or affiliation
- Telephone and/or fax number
- E-mail address

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 SHP 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 30 (thirty) calendar days of the receipt of the termination notice. The appeals notice must be submitted in writing to the Provider Relations Department’s Appeals Coordinator, to SHP’s address.

SHP 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”, SHP shall provide to all appropriate agencies the reasons for termination.

In cases in which a patient’s health is subject to imminent danger due to a provider’s action or inaction 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 all parties shall be immediate.

Provider-Required Incident Reporting

In the event of an adverse or untoward incident defined as a Code 15 case by the Agency for Health Care Administration (AHCA), whether occurring in a facility of one of the Plan’s providers or arising from health care prior to admission to a facility that occurs to a Plan member which may result in:

- The death of a member
- Fetal death
- Severe brain or spinal damage to a member
- A surgical procedure being performed on the wrong member or the wrong site
- A surgical procedure unrelated to the member’s diagnosis or medical needs being performed on a member
- Surgical procedure to remove foreign objects remaining from a surgical procedure
- Surgical repair of injuries from a planned surgical procedure
- Unplanned fracture or dislocation during a planned procedure

**These incidents must be reported to the Plan’s Quality Management Department on the Incident Report Form located in the Forms section of this handbook.**
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 SHP member, accompanying person or caregiver at a Plan’s participating provider premises
- A SHP 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

These incidents must be reported to the Plan’s Risk Management Department on the Incident Report form located in the Forms section of this handbook.

Further reporting to the Plan’s insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed time frames by the Plan’s Risk Manager. Physicians are reminded that serious negative events or incidences which occur in a provider’s office or facility must be reported to AHCA directly by the provider.

**Delegated Providers**

All participating providers or providers delegated for Network Management and Network Development or any other functions are required to meet all applicable standards. Reviews are performed prior to delegation and monitored on a regular basis to ensure compliance standards requirements are met.

**Medicare Risk Adjustment**

The CMS-Hierarchy of Conditions Categories (HCCs)/Risk Adjustment model strengthens the Medicare program by ensuring that accurate payments are made to Medicare Advantage Organizations, such as Simply Healthcare Plans ("Simply"), based on the health status of their Members. Accurate payments to Medicare Advantage Organizations help to ensure that providers are paid appropriately for the services rendered to Members and provide incentives to enroll and treat less than healthy individuals.

**Importance of HCC/Risk Adjustment to Providers**

While procedure codes are important for provider reimbursement of services to fee-for-service Medicare beneficiaries, the HCC/risk adjustment payment model relies on ICD-9CM diagnosis code specificity.

**Provider Responsibilities**

a) **Maintain Accurate and Complete Medical Record Documentation**

- Quality documentation leads to correct code specificity and accurate risk adjusted payment.
- Includes main reason for episode of care, all co-existing, acute and chronic conditions, and pertinent past conditions that impact clinical evaluation and therapeutic treatment.
- Document co-existing conditions during a face-to-face encounter at least once during reporting period.
- Document fully the specified type of common conditions, if known. For example, specific type of anemia, pneumonia, depression, etc.
b) Report Claims and Encounter Data in a Timely Manner

1. Under the HCC/risk adjustment model, providers must submit the following elements to Simply:
   - ICD-9CM diagnosis code
   - Service from date
   - Service through date
   - HIC # of the member

c) Report ICD-9CM Diagnosis Codes to the Highest Level of Specificity and Report These Codes Accurately

1. Combination codes
   - Related conditions that can be expressed with one code. (e.g. Hypertensive heart or renal conditions) “Code also” instructs when more than one code are needed. (e.g. Diabetic manifestations)

2. Digit specificity or coding to the fourth or fifth digit impacts risk adjustment payment. (e.g. MI and Diabetes)

3. Do not code:
   - Symptoms that are common to the main diagnosis
   - “History of” codes that are no longer pertinent to the current problem
   - “Rule out” codes of outpatient and physician visit

d) Alert Simply of Any Erroneous Data That Has Been Submitted and Correcting the Data in a Timely Manner.

Risk Adjustment Validation Data

a) Risk adjustment data validation is the process of verifying that a diagnosis code submitted by Simply to CMS is supported by medical record documentation. CMS validates medical records to ensure payment integrity and accuracy.

b) Steps in the Data Validation Process:
   - CMS selects a sample of Simply members and requests medical records from the health plan.
   - Simply requests member medical records from providers.
   - Simply sends the requested medical records to the CMS validation contractor for validation.

c) Provider Responsibilities:
   - Consistently follow general principles of medical record documentation.
   - Ensure all documentation to support a reported diagnosis on a given date or range of dates is provided.
   - Include supporting documents referred to in the encounter notes, such as test results or problem lists.
   - Respond quickly and send all records in an organized, secure and confidential manner.

SECTION 4

UTILIZATION MANAGEMENT DEPARTMENT
Overview

SHP’s Utilization Management (UM) Department will be responsible for the following processes:
- Receive notifications of admissions and other services
- Referrals and Quick Authorization Form
- Prior Authorizations (Pre-service requests)
- Concurrent Review of acute, sub-acute and skilled nursing facility admissions
- Discharge planning assistance
- Care Management services, including case management, disease management, chronic care and transition of care needs

SHP 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.

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. SHP uses two types of forms and processes:

1. **Quick Authorization Form (QAF)**

   For those services included on the SHP Quick Authorization Form (QAF) (see the Forms Section of this handbook) a referral is NOT required for participating providers. 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 Quick Authorization Form (QAF) without contacting the health plan for prior authorization.

   **IMPORTANT NOTE:** Communication with the Plan prior to the provision of care is not necessary when using the QAF; however, all inpatient services, outpatient hospital services (including diagnostics), and ASC services do require an authorization (see section below).

   Prenatal care referrals are NOT to be made using the QAF.

   **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.

   **Services that Do NOT Require Prior Authorization or QAF:**
   - 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
• Urgent services

2. Prior Authorizations:
Prior authorization (pre-service requests) allows for the use of quality, cost-efficient covered health care 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.

SHP’s UM Department evaluates requests for services/procedures and makes determinations based on medical necessity, covered benefits and appropriateness based on Medicare National and Local Coverage Determinations, SHP’s approved utilization criteria (Interqual) 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 SHP 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 the SHP’s UM Pre-Certification Department.

Prior Authorization or Notification Process:
• Providers are to fax the Referral & Authorization Form (refer to Forms Section) to the SHP’s Utilization Management Pre-Certification Department at Fax number 1-800-283-2114 or by calling the PreCertification Telephone Queue 1-800- 887-6888, ext 2271.
  ▪ Routine (NOT STAT/URGENT) requests are generally processed within 3 - 4 days and never processed in more than fourteen (14) calendar days of the Plan receiving the authorization request and having received all supporting clinical information.

  STAT/URGENT requests are processed within seventy-two (72) hours of the Plan receiving the request and having received the supporting clinical information. SHP strives to process the urgent requests as soon as possible.

NOTE: STAT/URGENT Authorizations should be CALLED IN to the SHP Pre-Certification Authorization Telephone Queue and NOT faxed, and the caller should identify the request as “STAT/URGENT”. These requests should always meet the defined medical criteria for such which are:
  STAT/URGENT = Any condition where failure to issue an immediate response may result in an IRREVERSIBLE SIGNIFICANT, ADVERSE outcome of health and/or function.

• 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 SHP computer system for future reference and claims payment.

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

- Member demographic information (i.e. name, sex, DOB, SHP Member Number)
- Provider demographic information
  - Requesting provider (i.e. name, SHP Provider Number, phone number, fax number, contact person)
  - Referred-to specialist/facility (i.e. name, SHP 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-9 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.

**Services and procedures that require prior Plan Notification and must be provided in a SHP participating facility** include but are not limited to:

- Inpatient and Observation Admissions, as noted above
- Admission to any rehabilitation or skilled nursing facility
- All surgical procedures, inpatient or outpatient
- Services and items:
  - Allergy (immunotherapy), except for those services identified on the QAF
  - Ambulance transportation (non emergent)
  - Amniocentesis
  - Cardiac and pulmonary rehabilitation programs
  - Court-ordered services
  - Chemotherapy
  - Dialysis
  - DME, including apnea monitors and bili-blankets
  - Upper endoscopies and 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 (outpatient surgical setting) and 24 (freestanding outpatient surgical facility
  - 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
• Physical, Occupational and Speech Therapy
• Radiation therapy
• SPECT scans
• Sclerotherapy
• 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 24 hours a day, seven days a week, 365 days a year.

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 lay person 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 impairment to bodily functions
- Serious dysfunction of any bodily organ or part

SHP 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 SHP 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 SHP 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. SHP 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, SHP 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 an enrollee
of SHP, the hospital must make a reasonable attempt to notify the enrollee's PCP, if known, or SHP, 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, does not know the enrollee's PCP, or has been unable to contact the PCP, the hospital must notify SHP 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 SHP, the hospital must document its attempts to notify the Plan, or the circumstances that precluded the hospital's attempts to notify the Plan. SHP shall not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.

SHP 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. SHP 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-service area and out-of-the-country 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 service area 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 SHP
- Post-stabilization care services that were not pre-approved by the Plan because SHP 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 include, but are not limited to:

- Acute hospital and long term care hospital stays
- Rehabilitation hospital care
- Medical supplies, drugs and biologicals, diagnostic and therapeutic services
- Use of facilities, room and board, nursing care
- 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.

Non-Routine Dental Care Covered Under Outpatient Services

Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)

Hospice

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

- Be eligible for Medicare
- 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

Hospice is a program of care and support for people who are terminally ill. It is available as a benefit under Medicare Hospital Insurance (Part A). The focus of hospice is on care, not treatment or curing an illness. Emphasis is placed on helping people who are terminally ill live comfortably by providing comfort and relief from pain.

Some important facts about hospice are:

- A specially trained team of professionals and caregivers provide care for the “whole person”, including his or her physical, emotional, social and spiritual needs.
- Services may include physical care, counseling, drugs, equipment, and supplies for terminal illness and related condition(s).
- Care is generally provided in the home
- Hospice isn’t only for people with cancer.
- Family caregivers can get support.

When all the requirements are met, the Medicare hospice benefit includes:

- Physician and nursing services
- Medical equipment and supplies
- Outpatient drugs or biological for pain relief and symptom management
- Hospice aide and homemaker services
- Physical, occupational and speech-language pathology therapy services
- Short term inpatient and respite care
- Social worker services
• Grief and loss counseling for the member and his or her family

When a member/patient enrolled in hospice receives care from your practice or facility, it is very important that all of the care be coordinated with their hospice physician. Once a Member is enrolled in hospice, Simply is not financially responsible for any services related to the hospice diagnosis . The Plan will continue to assist in coordination of the member’s care to the best of its ability, however, the payment process to providers changes.

For Hospice diagnosis-related care, providers need to bill the Medicare-approved hospice organization with which the patient is enrolled. For care not related to the hospice related diagnosis, that is a Medicare covered benefit, Simply participating providers need to bill the health plan. Non-participating providers need to bill Medicare’s Fiscal Intermediary. If a Member’s hospice is revoked during a month, you must continue to bill the hospice organization or the Fiscal Intermediary for CMS through the end of that month. Simply is responsible for additional benefits not covered by Medicare, i.e. the transportation benefit. Any claims received by Simply for Medicare-covered services that are related to the hospice diagnosis or that are not additional plan benefits, will be denied by the Plan.

**Note:** A member who has elected hospice and requires medical treatment for a non-hospice condition can do one of the following:

1. Use plan providers and services. In such a case, the member only pays Plan allowed cost-sharing, and the provider would directly bill Simply Healthcare Plans.
2. Use non-network providers and be treated under FFS. In such a case, if the service is not emergent/urgent care, the member would pay the total FFS allowed cost-sharing. The provider bills Medicare’s Fiscal Intermediary.

When hospice services are requested by a Member, confirmed with the Centers for Medicare & Medicaid Services (CMS) and updated in the Plan’s system, the Member is sent a new enrollment card reflecting a new group number beginning with RH*. This process may take time, depending on when the Hospice Form is received by CMS and when their system is updated.

It is important that your staff and/or billing company understands the process required to bill the Fiscal Intermediary for CMS for members of our Plan that are enrolled in hospice. Please communicate this information to your staff and/or billing company as appropriate.

**Contact Information for the Fiscal Intermediary is as follows:**
**First Coast Service Options, Inc.**
- Medicare Part A: Provider Contact Center - (888) 664-4112
  - IVR System - (877) 602-8816
    - Medicare Part B: Provider Contact Center - (866) 454-9007
  - IVR System - (877) 847-4992

**Additional Resources:**
Medicare Claims Processing Manual – Chapter 11: Processing Hospice Claims (Revised: 4/28/10)
  Section 40.2.2 – Claims from Medicare Advantage Organizations

**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 InterQual’s Observation 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.

**Out-of-Network Requests for Non-Emergency Services**

SHP will provide timely approval or denial of authorization of out-of-network use through the assignment of a reference number. Written follow-up documentation of the decision will be sent to the out-of-network provider within one (1) business day from the request. The member will be liable for the cost of unauthorized services from non-participating providers.

**Mental Health**

Mental health referrals and services are processed and determinations issued by Concordia, Simply’s behavioral health provider network. Inpatient mental health services will be covered for up to 190 days lifetime limit and will be provided in a Medicare-Certified facility. The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when the members enroll in a Medicare Advantage Plan.

- By calling 1-877-698-7787, or Via the web at [www.Concordia.com](http://www.Concordia.com), or
- By fax at (305) 514-5321 - Use the Concordia Referral Forms (Refer to the Forms Section)

Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for behavioral health services.

SHP 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 Concordia 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 SHP, please call Concordia or SHP Member Services so that the care is not interrupted.
- Services include individual, group and family therapy or evaluations, treatment planning, social rehabilitation, day treatment

**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 health care, and to call their PCP later as soon as they can.
- SHP will cover all emergency mental health care whether the member is in or outside the service area, at any time.
- Members may call Concordia at 1-877-698-7787 for assistance finding behavioral care in the area where they are.
- After the initial emergency treatment, SHP will cover the post-stabilization care services, even without authorization. Crisis intervention services are covered.

**Second Surgical Opinions**

Medicare covers second surgical opinions in some cases for surgery that isn’t an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

**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. SHP may request reports on the ongoing status of the member’s condition from the provider.

**Continuity and Transition of Care Needs**

**What if a specialist or another network provider leaves our plan?**

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens you will need to switch to another provider who is part of our plan’s network. If there is a significant change in your provider network, we will send you a letter notifying you of the change. The notification describes the changes in your provider network and the effective date of the change. The notification you will receive from us will contain specific information depending on the type of provider that is leaving the plan. If you are currently receiving active treatment from this specialist provider, your PCP will coordinate with the plan to coordinate prior approval for continuity-of-care services, until such time as it is medically safe to coordinate your transfer of care to a plan network provider specialist, as per Medicare guidelines.

**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 needs and ensuring that the member is discharged to the appropriate level of care to prevent readmissions and unscheduled transition of care.

SHP’s Concurrent Review Nurses 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 the SHP Care Management Team.

**Care Management Services**
SHP is committed to early identification of those members who may be at risk for health care 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.

The SHP Care Management Team will regularly monitor members with ongoing medical conditions and coordination of services for over and under utilization 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 health care 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, as identified, and are available through the Plan.

The SHP’s UM Care Management Team follows the Interdisciplinary Care Team (ICT) approach, with the Primary Care Physician (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 SHP’s UM Care Management Team by calling 1-800-887-6888 ext 2271 or faxing at 786-441-4607 or 1-877-577-0117.

Simply Healthcare Plans (SHP) Utilization and Medical Criteria Resources:
The following sources are utilized by SHP in helping to make Plan determinations. These include, but are not limited to:

- **CMS’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)**
- American College of Physicians guidelines
- Department of Health & Human Services, U.S. Preventative Services Task Force (USPSTF)
- Centers for Medicare and Medicare Services (CMS)
- InterQual Clinical Decision Support Criteria
- Nationally recognized, evidence-based guidelines (See Section 8 of this Handbook)

Adverse Determinations

SHP 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) SHP 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 14 for member appeals.
SECTION 6
COVERED SERVICES

COVERED SERVICES INCLUDE:

Covered Services are subject to Authorization requirements, contact the Plan for details.

Care Management and Disease Management: Available to all members through the UM’s Care Management Department. Please contact the UM Care Management Department for information and to refer members.

Interpreter Services and Services for the Hearing or Vision Impaired – please call the SHP Member Services number on the back of the member’s ID card. The services are free of charge.

Transplants – If medically necessary, covered by Medicare, and if the member has qualified as a transplant candidate Please contact the Plan for details.

Physician Services

Physician Services – Services when medically necessary for preventive, diagnostic or treatment of a particular illness. Services rendered by a participating physician including the member’s Primary Care Physician, Specialist, Chiropractor or Podiatrist. Contact the Plan for exclusions and details.

Podiatry Services – Medically necessary foot care provided by a participating podiatrist. Members are eligible for supplemental routine visit(s) every year.

Home Health Care - Includes medically necessary part-time or intermittent skilled nursing and home health aide services. All services must be provided by a participating provider and there are a limited amount of daily and weekly visits.

Inpatient Hospital Services – See Section 4.

Mental Health Services – Inpatient and outpatient hospital services for a number of psychiatric conditions, psychiatric physician services and Community Mental Health services. See our contact information for Concordia in Section 1.

Outpatient Services

Outpatient Services – Medically necessary medical or surgical services provided in an outpatient hospital setting, which include but are not limited to: physical therapy, occupational therapy, cardiac and pulmonary rehabilitation. All require prior authorization.

Ambulance Services: Covered for emergency transportation to the nearest appropriate facility. In non-emergent situations they are covered if the member’s condition is such that other means of transportation are contraindicated.

Diabetes and Education and Supplies – For all people who have diabetes and when medically necessary.

Durable Medical Equipment - Certain medical equipment for use at home, which includes but is not limited to crutches, canes, walkers, commodes, wheelchairs, oxygen and oxygen-related equipment.

Emergency Services – Described in Section 4
Renal Dialysis – Outpatient Hospital Facility & Freestanding: Include dialysis-related supplies and routine laboratory tests and other necessary items. Services included all medically necessary services and procedures rendered by a participating provider.

Independent Laboratory Services and X-Rays - When ordered by a participating provider.

Preventive Services

Immunizations – Flu shots, Pneumonia vaccine, Shingles vaccine, Hepatitis B vaccine for those at risk. Members who are at risk and meet Medicare Part B coverage rules could be covered for other vaccines. Some vaccines are covered under the Part D benefit.

Prescription Drugs – Part B

Medicare Part B Prescription Drugs
These drugs are covered under Part B of Original Medicare. Members of Simply receive coverage for the following drugs through our plan. Some limitations, restrictions, coinsurance and/or copayments may apply.
- Drugs that usually are not self-administered by the patient and are injected or infused in a professional setting.
- Drugs taken using durable medical equipment (i.e., nebulizers) that is authorized by the Plan.
- Clotting factors, self-administered through injections if the member has hemophilia.
- Immunosuppressive Drugs, if the member was enrolled in Medicare Part A at the time of the organ transplant.
- Injectable osteoporosis drugs
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.

Prescription Drugs – Part D

Medicare Part D Prescription Drugs
COVERED: All plans are required to have formularies or preferred drug lists (PDLs) that address all medically necessary drugs. Six (6) drug classes of special concern have been specified in which all or substantially all drugs will be on a plan’s formulary: anti-neoplastics, anti-HIV/AIDS drugs, immunosuppressants, anti-psychotics, anti-depressants and anti-convulsants.

NOT COVERED: By law, there are certain types of drugs that Medicare must exclude from Part D:
*barbiturates; *benzodiazepines; drugs used for anorexia, weight loss or weight gain; fertility drugs; drugs used for cosmetic purposes or hair growth; cough and cold medicines; prescription vitamins and minerals and over-the-counter drugs.

For your patients who have both Medicare and Medicaid, check with your state Medicaid program as most programs are continuing to cover all or some of these excluded drugs. Go to: www.cms.hhs.gov/States/EDC/list.asp#TopOfPage, to check which states cover these excluded drugs.

*Simply covers a few of the excluded barbiturates, benzodiazepines, and erectile dysfunction drugs. Please contact the Plan for details.
You may access the Simply’s Preferred Drug List on our website at http://simplyhealthcareplans.com/medicare/pharmacy/formulary/index.html


Additional Benefits

**Dental Services:** One cleaning every 6 months, one oral exam every 6 months and one dental x-ray once a year. The plan offers additional comprehensive dental benefits. Members can call the plan for assistance in locating a participating provider.

**Hearing Services – Basic hearing evaluations and additional covered services including but not limited to:** Up to 1 hearing aid per calendar year.

**Vision Services** – Services include but are not limited to: one visit per year for a routine exam and a plan coverage limit for eyeglasses, hardware or contact lenses. Please contact the Plan for details.

**Transportation Non-Emergency** – Covered by the Plan for medical care and to approved locations which are requested by the members Primary Care Physicians. Contact the Plan for restrictions and details.

**Over the Counter (OTC)** – Members of most of our plans are eligible for a monthly benefit to be used towards the purchase of over the counter (OTC) health and wellness products (non-prescription drugs) available through the plans OTC provider. For details please contact the plan.

**Health and Wellness**

The Plan offers health and wellness programs that address such concerns as fitness and nutrition. Please contact the Plan for further details.

- **Silver and Fit®**
- **Meal Program**
SECTION 7  
MEMBER RIGHTS AND RESPONSIBILITIES

Overview
This section explains Simply Healthcare Plans member’s rights and responsibilities, as is included in the SHP Member Handbook. Florida law requires health care providers and facilities to recognize member rights while they are receiving medical care or services and that the member respect the health care 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
SHP Members have the right to:

- be treated with courtesy and respect, and with due consideration of his/her dignity and privacy.
- confidentiality regarding disclosures and the treatment of medical records.
- 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 health care, including the right to refuse treatment.
- be informed of access to after-hours and emergency care.
- 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 health care 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, including the credentials of the health care provider.
- 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 SHP
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- Be informed that they can change providers if other qualified providers are available.
- 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 health care provider or health care facility which served him/her and to the appropriate state licensing agency
• be informed and be allowed to have a written Advanced Directives, as required by State and/or federal regulations
• be provided with appropriate information regarding absence of malpractice insurance company

SHP Members are responsible for:
• Providing to the health care 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, including the use of over-the-counter medications and dietary supplements
• Reporting unexpected changes in their condition to the health care provider
• Reporting to the health care provider whether they comprehend a contemplated course of action and what is expected of them
• Following the treatment plan recommended by the health care provider
• Keeping appointments and, when they are unable to do so for any reason, for notifying the health care provider or health care facility
• Their actions if they refuse treatment or do not follow the health care provider’s instructions
• Assuring that the financial obligations of their health care are fulfilled as promptly as possible
• Following health care facility rules and regulations affecting patient care and conduct.
• Inform the provider about any living will, power of attorney and any other directive that could affect their care.
• Be respectful of all health care professionals, staff as well as other patients.
• Provide a responsible adult to transport him/her home from the facility and remain with him/her for twenty-four (24) hours, if required by the provider.

Services for Translations and the Hearing Impaired

All SHP eligible and potential members whose primary language is not English are entitled to receive interpreter services through SHP at no cost to the member by calling SHP Member Services at 1-800-213-1133. For the hearing impaired, TTD/TTY is 711 Florida Relay.

Advance Directives

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

• **Durable Power of Attorney for Health Care:** 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 health care providers.

Written Advance Directives tell the health care provider how the members choose to receive medical care in the event they are unable to make end-of-life decisions. SHP 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. PCP’s must discuss Advance Directives with members and provide appropriate medical advice if the members desire guidance or assistance. Under no circumstances may any SHP 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.
SECTION 8
PREVENTATIVE CARE AND CLINICAL PRACTICE GUIDELINES

Overview

Simply Healthcare Plans (SHP) 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 health care services and treatment is provided to the members.

Below you will find links to these guidelines. For questions or comments, please contact the SHP Utilization Management Department at 1-800-887-6888 ext 2271 or contact your Provider Relations Representative.

<table>
<thead>
<tr>
<th>Preventative Services</th>
<th>WEBSITE LINK</th>
<th>INFORMATION PROVIDED</th>
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<tr>
<td>Multiple</td>
<td><a href="http://www.guideline.gov">www.guideline.gov</a></td>
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<td>Development and behavior screening information</td>
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<td>Heart and Vascular Diseases</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#heartvasc">http://www.ahrq.gov/clinic/cps3dix.htm#heartvasc</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#heartvasc">http://www.ahrq.gov/clinic/tfchildcat.htm#heartvasc</a></td>
<td>Multiple heart and vascular related topics regarding prevention, screening and counseling</td>
</tr>
<tr>
<td>Mental Health Conditions and Substance Abuse</td>
<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#mental">http://www.ahrq.gov/clinic/cps3dix.htm#mental</a> Children and Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#mental">http://www.ahrq.gov/clinic/tfchildcat.htm#mental</a></td>
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<td>Adults: <a href="http://www.ahrq.gov/clinic/cps3dix.htm#musculo">http://www.ahrq.gov/clinic/cps3dix.htm#musculo</a> Adolescents: <a href="http://www.ahrq.gov/clinic/tfchildcat.htm#musculo">http://www.ahrq.gov/clinic/tfchildcat.htm#musculo</a></td>
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<td>Obstetric and Gynecological</td>
<td>Adults:</td>
<td>Multiple OB/GYN related topics</td>
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<tr>
<td>Conditions</td>
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<td>regarding prevention, screening and counseling</td>
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<td>Multiple perinatal care related topics regarding screening</td>
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<td>Multiple vision and hearing related disorder topics regarding screening</td>
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<td>COPD related screening information and dental and periodontal disease counseling</td>
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**Clinical Practice Guidelines Reference Guide**

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<th>TOPIC</th>
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<th>RESOURCE</th>
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<td>COPD</td>
<td><a href="http://www.healthquality.va.gov/Chronic_Obstructive_Pulmonary_Disease_COPD.asp">http://www.healthquality.va.gov/Chronic_Obstructive_Pulmonary_Disease_COPD.asp</a></td>
<td>U. S. Department of Veterans Affairs,</td>
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<td>Diabetes</td>
<td><a href="http://care.diabetesjournals.org/content/35/Supplement_1/S11.full">http://care.diabetesjournals.org/content/35/Supplement_1/S11.full</a></td>
<td>American Diabetes Association, Diabetes Care, Standards of Diabetes Care 2012</td>
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<td>Hemophilia</td>
<td><a href="http://www.wfh.org">www.wfh.org</a></td>
<td>World Federation of Hemophilia, Diagnosis and Treatment Guidelines, Last Updated February’ 09</td>
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<tr>
<td>Condition</td>
<td>Reference</td>
<td>Organization/Update Details</td>
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<td>U.S. Dept. of Veterans Affairs, Reviewed/Updated Nov. 2009</td>
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For Medicare National and Local Coverage Determinations, see

SECTION 9
MEDICAL RECORD STANDARDS

Overview

All SHP physicians are required to maintain a complete electronic or paper medical record for each SHP 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 health care 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

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

Medical record documentation, at a minimum, must be legible, detailed 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 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
  - Medical diagnosis or impression, including behavioral health conditions
  - 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
  - Name and profession of the provider rendering the services (i.e. MD, DO, DDS, PA, ARNP), 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;
- The date/time the call was returned 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 the member’s primary language spoken and any translation services that are needed
- Documentation of any communication assistance needs that are needed for the delivery of health care 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 health care 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 an Advance Directive
  NOTE: Simply Healthcare Plans, 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 SHP responsible for the payment of diagnostic or therapeutic intervention as part of clinical research
- A release document for each SHP member authorizing SHP 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

Providers must retain all SHP member’s medical records for a minimum of six (6) years
Medical records must be made available for quality care review studies by Plan reviewers, authorized representatives of the Agency for Health Care Administration (AHCA), the Department of Health and Human Services (DHHS), Department of Financial Services, Centers for Medicare & Medicare 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
Medical Records Audits and Compliance

In order to comply with regulatory and accreditation requirements, the SHP Quality Management Department conducts medical records audits in physician offices. The members’ medical records will be reviewed for content and screenings, as applicable. Physicians will be given results at the time of the audit and a corrective action plan will be required if the score is equal to or less than 85 percent.

It is the provider’s responsibility to comply with Corrective Action Plans imposed as the result of any such audit or review.
SECTION 10
QUALITY MANAGEMENT

Overview

SHP 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 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 health care 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 health care 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 contributes to a high level of clinical and service outcomes include, but are not limited to:

- Care Management Programs:
- Diabetes Management Program;
- CHF Management Program;
- Chronic Care Improvement Program;
- Preventative Care and Clinical Practice Guidelines
- Care Management and Model of Care for Special Needs Plans members

SHP offers disease management programs to help members understand and manage chronic health conditions they may have. Our Care Managers For more information on disease management programs available, please call our Care Management Department.

Other Resources for you to assist our members
- Domestic Violence Hotline- Florida:1-800-500-1119. 24 h./day, 7 days/week
- Florida Quit for Life – 1-877-822-6669 to quit smoking
- www.smokefree.gov for online resources, information and booklets on how to quit smoking.

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.

SHP’s Quality Management (QM) 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 QM 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. A Corrective Action Plan will be requested for all identified deficiencies.

**Providers Right to 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 Credentialing Committee 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.

SHP 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 health care 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 under utilization 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 SHP’s policies and procedures. The Medical Director 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 Health Care 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 receive the written recommendation of the Committee, including a statement for the basis of the recommendations (which SHP will send to the provider within 10 days)
  - To receive a written decision of the Plan, including a statement for the basis of the decision (which SHP will send to the provider within 30 days)
* The provider needs to notify SHP of such representation at least ten (10) working days prior to the scheduled hearing. SHP 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 13, Provider Complaints, for Second Level Appeals. There is no further appeal for the decision of the second level appeal.

**Measurement of Clinical and Service Quality; HEDIS, CAHPS®, Provider Satisfaction Survey, Member Satisfaction Survey, and key quality metrics**

**CMS Star Rating**

The Centers for Medicare & Medicaid Services (CMS) uses a five-star rating system to measure Medicare beneficiaries’ experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS) and prescription drug plans (PDP). The scale ranges from one to five stars, where a rating of one star (*) represents “poor” quality and five stars (***** ) represents “excellent” quality. The program is a key component in financing health care benefits for MA plan enrollees. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing among the MA plans offered in their area.

**CMS Goals for the Five-star Rating System**

- Implement provisions of the Affordable Care Act
- Clarify program requirements
- Strengthen beneficiary protections
- Strengthen CMS’ ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers

**HEDIS - Healthcare Effectiveness Data and Information Set**

HEDIS is a set of performance measures established by the National Committee for Quality Assurance (NCQA) for the managed care industry. Each year, Simply collects data from a randomly selected sample of members’ medical records for HEDIS. Medicare Advantage Plans are required to report their results annually to the Center for Medicare and Medicaid (CMS), NCQA, CMS and the Agency for Health Care Administration (AHCA) use this information to monitor the performance of health plans.

HEDIS contains 76 measures across 8 “domains” of care:

- Effectiveness of care (Quality)
- Access/availability of care
- Use of services
- Cost of care
- Health Plan descriptive information
- Health Plan stability
- Informed health care choice
- Satisfaction with the experience of care
CAHPS

The CAHPS survey (Consumer Assessment of Healthcare Providers and Systems) is conducted annually by the Centers for Medicare & Medicaid Services (CMS) to assess the experiences of beneficiaries in Medicare Advantage plans. The survey is typically conducted in early spring of the reporting year by mail, with telephonic follow-up for non-responders. The CAHPS survey measures members’ experiences with the plan and its providers over the previous six months. The survey sample is drawn from all individuals who had been members of a plan for at least six months. Although beneficiaries provide ratings of their “plans,” the unit of analysis is not a health and/or prescription drug plan but rather a health and/or prescription drug plan contract. Simply contracts with a CMS-approved Medicare vendor to conduct the survey. Results are produced annually and compared to national benchmarks.

The survey has approximately 70 questions with the results reported in composites. Some questions apply to member satisfaction related to the service provided by the health plan and some reflect the member’s perception of the patient-physician relationship or communication.

The health plan will devise Quality initiatives to assist our partners in providing quality healthcare to our members in order to achieve excellent health outcomes as well as scores.

** Tips for Providers **

- Encourage patients to obtain preventive screenings annually or when recommended.
- Create office practices to identify noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Submit clinical data such as lab results to Simply.
- Communicate clearly and thoroughly; ask, “Do you have any questions?”
- Understand each measure you impact.
- Incorporate Health Outcomes Survey (HOS) questions into each visit. Find out more about HOS at http://www.hosonline.org/Content/SurveyInstruments.aspx.
- Review the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to identify opportunities for you or your office to have an impact: http://map-pdcahps.org/content/surveyinstruments.aspx.
SECTION 11
CULTURAL COMPETENCY PROGRAM

Overview

SHP has a comprehensive Cultural Competency Program to ensure that the Plan 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, SHP 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 SHP organization 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 SHP employee and provider training, both upon initial joining SHP and, at a minimum, annually. This integrated approach was developed so that cultural competency becomes a part of our everyday thinking.

SHP 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.

SHP 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

SHP’s 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.

SHP conducts initial and ongoing organizational self-assessments of CLAS (Culturally and Linguistically Appropriate Services)-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 implement strategies 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

- SHP 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 the SHP Cultural Competency Program 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 health care disparities in the minority populations where SHP delivers services
- Ensure providers and SHP employees are educated and value the diverse cultural and linguistic difference in the organization and populations served care

**Program Components:**

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

You may request a copy of SHP’s Cultural Competency Plan at no cost by calling SHP’s Provider Relations. A full copy of the plan is also available on the plan’s Provider Website.
SECTION 12
CREDENTIALING

Overview

SHP is responsible for all aspects of the credentialing and re-credentialing process for all providers who join or participate in the SHP Network. This process is under the QI Department Program and is designed to meet all regulatory and accreditation requirements and standards. In accordance with those standards, SHP members will not be referred or assigned to a provider until the credentialing process has been completed.

SHP recognizes and accepts the Council for Affordable Quality Healthcare’s (CAQH) credentialing information and application or SHP’s own practitioner application that includes specific profile elements as required by the State of Florida. SHP 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 SHP, you are required to submit adequate information that will allow the Plan to complete a thorough evaluation which includes your background, experience, education and training; demonstrate the ability to perform as an SHP provider without limitations, including physical and mental health status as permitted by law.

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

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
  - High Volume Behavioral Health Providers

- Once SHP’s 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 Committee (CRC)

- All SHP providers must be credentialed and approved by the CRC prior to their contract becoming effective
- SHP’s 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
- SHP’s 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 including but not limited to medical license, education and training, NPDB, etc., as well as the provider's and practice owner's participation and non-exclusion in government programs and the OIG (Office of the Inspector General), prior to being presented to the CRC.

**Re-credentialing**
- Once a provider is credentialed by the CRC to provide service for SHP’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 six (6) 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 SHP’s Provider Network as a non-compliant provider
- Information will be verified and presented to the CRC for re-credentialing include:
  - Basic qualifications continue to be met
  - Quality performance information (i.e. medical record reviews, member satisfaction surveys, Member Services reports)
  - Participation and nonexclusion in government programs and the OIG
- 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 SHP’s Provider Network

**Provider’s Right to Review**
Providers have the right to review his/her 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 SHP receives information that conflicts with information given by the provider, SHP 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 SHP 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, Attention: Credentialing Coordinator
1701 Ponce De Leon Blvd, Suite 300
Coral Gables, Florida 33134-4414

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

**Provider’s Right to be Informed**

Requests for application status update should be made by calling SHP’s Provider Relations Department at 1-800-887-6888 ext. 6005 or by regular mail or e-mail; SHP’s Provider Relations Department will respond to the request within three (3) working days.

SHP’s 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 13
PARTICIPATING PROVIDER COMPLAINTS

Participating providers may submit expressions of dissatisfaction or informal complaints to Simply Healthcare Plans, Inc. This usually includes issues with original authorization/referrals or claims determination and providers may request a re-review and re-determination on the initial adverse decision made, as well as any other administrative complaints they may have.

Providers are encouraged to first communicate any concerns or dissatisfaction about a SHP process or decision verbally through the Provider Relations telephone lines at 1-800-887-6888 ext. 6005 Monday through Friday between 8 AM and 7 PM EST, excluding state holidays. In the event a provider wishes to submit a formal grievance regarding any issue described above, the provider must document in writing the circumstances and forward to their designated Provider Relations Coordinator at:

Simply Healthcare Plans, Inc.
1701 Ponce De Leon Blvd
Coral Gables, FL 33134-4414
Toll Free Number: 1-800-213-1133
Attn: Provider Appeals Coordinator

Or, electronically at:

ProviderRelations@Simplyhealthcareplans.com

The letter will be reviewed by the Provider Relations Department and other plan departments as required in order to make a determination. A response will be sent within 60 days after receipt of the letter. The response will provide the appropriate next steps should the resolution not be favorable to the provider.
SECTION 14
MEMBER GRIEVANCES AND APPEALS

Definitions

**Complaint:**
Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan’s refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

**Grievance:**
Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

**Quality Improvement Organization (QIO):**
Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. The QIO’s review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient department, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIO’s also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and CORFs.

**Appeal:**
Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), reviews by the Medicare Appeals Council (MAC), and judicial review.

**Reconsideration:**
A member’s first step in the appeals process after an adverse organization determination; the health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

**Independent Review Entity:** An independent entity contracted by CMS to review Medicare health plans’ adverse reconsiderations of organization determinations.
**Formal Grievance Process**

Simply members have sixty (60) calendar days from the date of the occurrence to file a formal grievance to the health plan. Any member who has a grievance against Simply Healthcare Plans or its providers for any matter may submit an oral or a written statement of the grievance to Simply. A grievance form may be requested from the Member Services Department.

The oral or written grievance should include the following:

a. Member’s name and ID number  
b. Summary of occurrence  
c. Description of the requested assistance  
d. The member’s signature  
e. The date the grievance was signed

The written statement or the grievance form must be sent to the Grievance and Appeals Department at the following address or fax number:

**Simply Healthcare Plans, Inc.**  
1701 Ponce De Leon Blvd.  
Coral Gables, Florida 33134-4414  
Attn: Grievance & Appeals Department  
Fax: 877-577-0114

Grievances will be resolved in accordance with the Medicare Managed Care Manual mandated by CMS.

**24 hours for expedited grievances.** Expedited grievances exist whenever:

- The health plan extends the time frame to make an organization/coverage determination or reconsideration or redetermination; or
- The health plan refuses to grant a request for an expedited organization/coverage determination, reconsideration or redetermination; or
- Life threatening situations.

**30 calendar days for standard grievances.** Prompt appropriate action, including a full investigation of the grievance as expeditiously as the member’s case requires, based on the member’s health status, but no later than 30 calendar days from the date of the oral or written request is received, unless the case is extended.

Simply members will be referred to the Florida Medical Quality Assurance Inc., Florida’s Quality Improvement Organization (QIO), should the grievance be relating to the quality of care or service from the plan or its providers. Simply member’s may also send inquiries or call FMQAI directly at the following:

**Florida Medical Quality Assurance, Inc.**  
Florida’s Quality Improvement Organization (QIO)  
5201 Kennedy Blvd., Suite 900  
Tampa, FL 33609  
(800)844-0795
**Medicare Reconsideration (Appeal)**

A request for reconsideration (appeal) is a written request by the member (legal guardian, authorized representative, or power of attorney), or a non-participating provider, (who has signed a waiver indicating they will not seek payment from the member for the item or service in question). A physician who is providing treatment to the member, upon providing notice to the member, may request an expedited or standard reconsideration on the member’s behalf without having been appointed as the member’s authorized representative.

The request for a reconsideration of the plan’s initial determination to deny payment of a claim or authorize a service must be received within sixty (60) calendar days of receipt of an initial determination. A response of the decision determined by the plan for expedited cases will take no longer than 72 hours for situations where applying the standard time procedure could seriously jeopardize the enrollee’s life, health or ability to regain maximum function, thirty (30) calendar days for a standard service request and sixty (60) calendar days if the request is for the payment of a denied claim.

**Formal Appeal Process:**

1. Organization Determination
2. Appeal Reconsideration
4. Administrative Law Judge (ALJ) Hearing, if at least $130.00 is in controversy.
5. Medicare Appeals Council (MAC)
6. Judicial review, if at least $1,350.00 is in controversy.

**Appeal Reconsideration:**

A request for reconsideration (appeal) is received within sixty (60) calendar days of the adverse initial determination.

The Grievance and Appeals Coordinator assigns the case to the Grievance and Appeals Specialist for research. The Grievance and Appeals Specialist acknowledges the request for reconsideration (appeal) within five (5) business days of receipt. If a member’s issue involves both an appeal and grievance, they will be worked simultaneously by the same Grievance and Appeals Specialist.

In all cases, payment of claims or authorization for services and notification to member or non-contracted provider must be made within, 72 hours for expedited request, thirty (30) calendar days for a standard request for a service and sixty (60) calendar days for payment of a denied claim. If adequate information to make a determination is not received within the allowed processing time, a determination must be made based on the information received. (An extension of up to fourteen (14) calendar days can be made if requested by the member or if the plan justifies the need for additional information and it is in the best interest of the member). Members will be advised of their right to file an expedited grievance should they not agree to the extension of their appeal case.

If a decision cannot be made or if the denial is upheld in whole, or in part, the entire file is forwarded along with written explanation of the decision to MAXIMUS Federal Services, Inc. for a new determination by the required timeframe for each type of case. The member/appointed representative/treating physician/non-contracted provider is notified verbally and followed-up in writing.

MAXIMUS advises the member/appointed representative/treating physician/non-contracted provider and the plan of its decision in writing within the required time frames depending on the level of the appeal stating the reason(s) for the decision and inform the member/non-contracted provider of his or her right to a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration if the denial is upheld and the amount in controversy meets the appropriate threshold requirement.
If the denial is overturned by MAXIMUS, the request for a service is provided as expeditiously as the member’s health requires but no later than 72 hours for an expedited appeal, 14 calendar days for a standard service appeal or 30 calendar days for a standard claim appeals.

If the amount in controversy is at least $130.00, the member/non-contracted provider may appeal MAXIMUS’ decision by requesting a hearing before an Administrative Law Judge (ALJ). The request must be submitted in writing within sixty (60) days after the date of notice of the adverse reconsideration determination and must be filed with the entity specified in MAXIMUS’ reconsideration notice. If Simply receives a written request for an ALJ hearing from an enrollee, Simply must forward the enrollee's request to MAXIMUS.

An adverse decision or case dismissed by the ALJ can be reviewed by the Medicare Appeals Council (MAC), either by its own action or as the result of a request form the member/non-contracted provider or Simply. If the MAC grants the request for review, it may either issue a final decision or dismissal, or remand the case to the ALJ with instructions. MAC review must be requested in writing within sixty (60) days of the ALJ adverse determination.

If the amount remaining in controversy is at least $1,350.00, the member/non-contracted provider of Simply may request a Judicial Review. The review must be requested in writing within sixty (60) days of the MAC’s adverse determination.

The entity which makes an initial reconsidered or revised determination may re-open the determination. Re-openings occur after a decision has been made. Re-openings may be granted:

- To correct an error
- In response to suspected fraud
- In response to the receipt of information not available or known to exist at the time the claim were initially processed

A re-opening is not an appeal right. A party may request a reopening even if it still has appeal rights, as long as the guidelines of the re-opening are met. For example, if a member receives an adverse determination, but later obtains relevant medical records, he or she may request a re-opening rather than a hearing before an ALJ. However, if the beneficiary did not have additional information and just disagreed with the reasoning of the decision, he or she must file an appeal. If a member requests a re-opening while he or she still has appeal rights, he or she will also file for the appeal and ask for a continuance until the re-opening is decided. If the re-opening is denied or the original determination is not revised, the party retains its appeal rights.

The party that filed the reconsideration may withdraw that request. The withdrawal must be filed in writing to the Plan, the Social Security Office or the Railroad Retirement Board office (for railroad retirees). The withdrawal will be acknowledged in writing by the Plan.
SECTION 15

CLAIMS

Overview

The primary focus of SHP’s Claims Department is to process claims in a timely manner. The Claims Department is proactive and works closely with the SHP Provider Operations and Utilization Management Departments in trying to resolve any claims-related issues. SHP strives to follow AHCA guidelines for processing claims and payment. These guidelines are contained in the AHCA Provider Handbooks or may be viewed online by going to AHCA Florida Medicare Website: http://www.baccinc.org/medi/Opening_Page.htm

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.
Attn: Claims
PO BOX 21535
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 use good faith effort when billing SHP for services by using the most current coding (ICD-9, CPH, HCPCS, etc.) available. The following information is to be included on all claims submissions, electronic or paper:

1. Member’s name, date of birth, sex and ID number
2. Date(s) of service, place of service(s) and number of days or units, if applicable
3. Provider tax identification and NPI number
4. ICD-9 diagnosis codes by specific service to the highest level of specificity
5. Current CPT, revenue and HCPCS procedure code(s) with modifiers is appropriate
6. Billed charges per service(s) provided and total charges
7. Provider name and address, signature, and phone number
8. Information about other insurance coverage, Workers’ Compensation, accident or auto information, if available
9. Attach a detail description of the service or procedure for claim submitted with unlisted medical or surgical CPT or other revenue codes
10. For resubmissions and corrections of a claim, please submit a new CMS 1500 or UB-40 indicating the correction.
Claims must be submitted on the proper claim form, either a CMS-1500 or UB-04 and must contain the information noted above. SHP 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.

Filing a Claim Electronically

Providers submitting claims electronically should receive an acknowledgement from WebMD or their current clearinghouse; if you experience any problems with your transmission please contact your local clearinghouse representative.

Timely Claim Submission

- SHP providers will submit claims, as per Provider Contract, promptly to SHP for covered services rendered to the member
- SHP as Primary payer: Within six (6) months of service or as per the terms of your contract
- SHP 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 SHP within these time limits will not be eligible for payment and the provider hereby waives any right to payment thereafter

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 SHP. Payment is subject to the minimum standards as set forth by CMS.

Claims for Emergency Services

SHP 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 Medicare reimbursement rate established for the hospital or provider.

Florida Medicare 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 health care 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 SHP
- When filing a claim to SHP, you must include a copy of the other insurance's EOB with the claim
- If SHP is the secondary insurance, SHP will pay the member’s responsibility after the primary insurance carrier has paid, not to exceed SHP’s contracted allowable rate
- SHP 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: SHP 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. SHP 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 SHP 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 EOB or PRA will show the reason for the claim adjustment.
SECTION 16
INFORMATION ON COMPLIANCE & FRAUD, WASTE AND ABUSE

SHP 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.

SHP’s Compliance Officer oversees all the activities of our Compliance Program and reports any possible violations to the proper agencies. If you suspect a violation or an SHP member tells you of a possible violation please contact our Compliance Officer/Fraud Hotline at 1-877-253-9251, via fax to 786-441-4625, or email to SIU@simplyhealthcareplans.com

SHP instructs and expects all the 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 employees, associates, persons or entities 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, health care fraud, obstruction of a federal health care 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.

SHP is obligated to report any suspected cases of healthcare fraud, waste or abuse to the regulatory agencies and/or contracted CMS vendors, (NBI MEDIC). SHP may also consider reporting the conduct to other government authorities such as the Office of Inspector General or the Department of Justice.

In addition, the Agency for Health Care Administration (AHCA), Office of the Inspector General (OIG), Bureau of Medicare Program Integrity in tandem with NBI MEDIC, audits and investigates providers suspected of overbilling or defrauding the Florida Medicare Program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation to the Department of Justice. Program Integrity may also originate an investigation due to a complaint being filed.

Federal regulations require mandatory Compliance and Fraud, Waste 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 SHP, CMS or agents of 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.

Note: FDRs who are “deemed” to have met the FWA training and education requirements, are exempt from the above mandatory training, and will be required to submit copies of their certification to SHP. If you have Medicare billing privileges the FWA training was required to continue your participation in the Program.

If you or your employees have not taken the Compliance and or Fraud Waste and Abuse training, please log onto the SHP’s website under Medicare, then 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 CMS program requirements for your continued participation with the plan. You must maintain record of completion. During a Plan and or CMS review, you will be asked to provide evidence of completion for our files. This material should be readily available and at the Plans request.

It is important that you review certain federal regulations:

1. **The False Claims Act**
   
   SHP 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 SHP maintains ultimate responsibility for adhering to all terms and conditions of its contract with state and federal programs, SHP 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 health care programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other Federal health care 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. SHP 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, health care clearinghouses and certain health care 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 Medicare Services (CMS) is the Departmental component responsible for implementing and enforcing the other HIPAA regulations.

   **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 without a written authorization.1

   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 health care 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 health care operations activity.”

SECTION 17
SIMPLY HEALTHCARE SPECIAL NEEDS PLANS AND THEIR MODEL OF CARE

Under the MMA (Medicare Modernization Act) of 2003, Congress created a new type of Medicare Advantage Plan so that Medicare beneficiaries with special needs would benefit with increased, focused coordination of care. These beneficiaries are usually older, with multiple medical conditions, often with social challenges, and therefore more care needs.

Special Needs Plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals identified by Congress. Simply has chosen to target the Medicare beneficiaries who are also eligible for Medicaid (Dual-Eligibles) as well as members living in institutions such as nursing homes and members living in the community who require and institutional level of care based on the State of Florida’s CARES assessment.

The core of the SNP is to provide improved coordination, access, and continuity of care for this population. In addition, they will have the opportunity of enhanced benefits by combining those available through Medicare and Medicaid and other add-on benefits.

The SNP will focus on monitoring health status of the target population, identifying their needs, improving access to quality healthcare services and benefits, managing chronic diseases, avoiding inappropriate hospitalizations, and helping the members decrease their medical, mental, and social risks.

The Model of Care provides the structure for evidence-based care management, member outreach, coordination, improved access to care, benefits, and services with improved outcomes, communication and outcomes data and reporting requirements.

The Care Management team enrolls the members who ‘opt-in” in the Care Management program and is responsible for coordinating care management benefits, services and outreach and communicating with the member and his/her provider.

You have received or will receive training on the Model of Care. These is just a summary for your reference:

MODEL OF CARE ELEMENTS

1. SNP-Specific Target Population
2. Measurable Goals
3. Staff Structure and Care Management Roles
4. Interdisciplinary Care Team
5. Provider Network with Expertise and Use of Clinical Practice Guidelines
6. Model of Care Training for Personnel and Provider Network
7. Health Risk Assessment
All SNP members receive an initial Health Risk Assessment (HRA) within ninety (90) days of enrollment. Based upon the answers noted in the HRA, the member may be referred for additional Case Manager assessment/intervention at which time any identified health care needs would be identified, through the General Health Assessment tool, that screens for potential medical, medication, social, cognitive impairment, and behavioral health needs so access can be coordinated for affordable care and services that are appropriate to the member's level of care, goals developed, identification of the point of contact through the Interdisciplinary Care Team (ICT), identify educational opportunities and the need for preventative services, and on-going assessment to ensure that goals were met, when possible.

You, the provider, are a vital member of the Interdisciplinary Care Team (ICT) and our Care Management Team will contact you to discuss the Care Plan of SNP members. The members and the Plan appreciate your invaluable input and support.
SECTION 18
SIMPLY HEALTHCARE PLANS FORMS

1. Referral and Authorization Form
2. Quick Authorization Form
3. Concordia Referral Form
4. State of Florida Acknowledgment of Receipt of Hysterectomy Information
5. State of Florida Exception to Hysterectomy Acknowledgement Requirement Form
6. Incident Report Form
7. PCP Initiated Member Transfer Form
8. Appointment of Representative
Referral & Authorization Form
Fax #: 1-800-283-2117

Please complete all areas on the form and attach pertinent clinical information to avoid delays.

**Urgent is defined as potential impact to the health of the enrollee if referral is not completed within 72 hours**

TOTAL NUMBER OF PAGES IN THIS FAX INCLUDING THIS ONE: _____

Date: __________ Contact Person: ________________________________

Requesting Provider: ______________________  PCP NAME: ______________________  PROVIDER #: __________________

Phone #: __________________ Fax #: ________________________________

☐ INITIAL REQUEST  ☐ URGENT  ☐ ROUTINE  ☐ REQUEST FOR AN EXTENSION

**PATIENT INFORMATION**

Member Name: ____________________________ Member ID #: ________________________ D.O.B: __________

LOB: Medicare __________________ Medicare ______

Is the Referral related to an accident? __Yes ___No  ___MVA ___Workmen’s Comp

Other insurance name and policy, if any: ________________________________________________

**SPECIALIST OR OTHER SERVICING PROVIDER INFORMATION**

Provider Name: ____________________________ Provider ID: __________________________

Address: __________________________________ Fax #: __________________________

Date of Service/Appt: ____________ PAR ______ Non-PAR _____

**CLINICAL INFORMATION**

Diagnoses: ______________________________________________________________

ICD-9 Codes: ____________________________ CPT/HCPCS Codes: __________________

Procedures: ______________________________________________________________

Number of visits requested: ______ Duration ______ Frequency ____________________

If this is a request for an extension or a recurrent request, please state # of previous visits: ______________________

**TYPE OF SERVICE REQUESTED**

☐ Bariatric Surgery  ☐ DME  ☐ Home Health  ☐ Hysterectomy*  ☐ MRI  ☐ MRA  ☐ PET Scan  ☐ PT/OT/ST


☐ Transplant Evaluation  ☐ Abortion*  ☐ Pain Management  ☐ Prenatal Notification

☐ Other _________________________________________________________________

☐ Out of Network (Please explain): __________________________________________

Name of Out-of-Network Provider and phone #: ______________________________________

*Include State Requirements
**MEDICARE SOUTH FLORIDA**

**QUICK AUTHORIZATION FORM FOR PARTICIPATING PRIMARY CARE PHYSICIAN ONLY**

**VALUED FOR 90 DAYS**

**VALID FOR: 1) SPECIALIST CONSULTATIONS; 2) LISTED OFFICE PROCEDURES; 3) FREE-STANDING DIAGNOSTIC**

**DO NOT USE FOR HOSPITALS, ASCs OR FOR PRENATAL CARE VISITS/TREATMENT. DO NOT WRITE IN OTHER CODES. PRECERTIFICATION IS REQUIRED FOR SERVICES/CODES NOT LISTED BELOW. YOU MAY MAIL THIS COMPLETED FORM TO THE SPECIALIST AND GIVE A COPY TO THE MEMBER.**

For questions, call 1-877-915-6551, Prompt 2

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INCIDENT REPORT FORM - PRIVILEGED AND CONFIDENTIAL

Please complete the following:

Product: (circle one)  Medicare  Medicare  Commercial

MEMBER NAME: ________________ MEMBER NUMBER: ___________ DOB _____ SEX____

INITIAL DIAGNOSIS: ___________________________ INITIAL ICD-9 CM CODE: ____________

INCIDENT TIME: _____ INCIDENT DATE: __________ INCIDENT LOCATION: ____________

FACILITY NAME (If hospitalized): ______________ ADMISSION TIME & DATE: __________

ADMITTING DX & ICD-9 / CPT CODE: __________ WAS A PHYSICIAN CALLED? _____

PCP: ____________ SCP: __________________

WITNESS (ES): _________________________________________________________________

WITNESS (ES) LOCATING INFORMATION:

____________________________________________________________________________

PHYSICAL FINDINGS/DIAGNOSIS:

____________________________________________________________________________

Give a clear concise description of the incident including time, date, and exact location:
____________________________________________________________________________

____________________________________________________________________________

FINAL DX ICD-9 / CPT CODES: __________________________________________________

Attach information if more space is needed.

REPORT PREPARED BY:

NAME: ___________________ POSITION: ______________ SIGNATURE: ____________

Date of Report: ___________ Time of Report: ________________

INCIDENT REPORTS MUST BE SENT TO RISK MANAGEMENT WITHIN 3 CALENDAR DAYS-
PLEASE CALL SHP’S RISK MANAGER BEFORE FAXING
Simply Healthcare Plans, Inc.
Physician Initiated Transfer Request Form (Page 1)

Member's/POA Name(s):____________________________________________________
ID Number: ____________________ Effective Date: _______________________
Date of Birth: _______________ Phone: _______________________
Address: ______________________________________________________________
City, State, Zip: __________________________

1. Justification for proposal to transfer this member is as follows: (Cite specifics as to frequency and type of demonstration disruptive, unruly, abusive or uncooperative behavior. Include details and sequence of events. Use additional sheets if necessary.)

2. Mental status of member – behavioral health:

3. Functional status of member

4. Diagnosis and medical summary of member's condition

5. Social supports systems available to member:

6. Summary of efforts to resolve problem:

7. Other options offered to member prior to consideration of transfer:

8. Attach separate statement(s) medical records and other appropriate documentation, e.g. police report, from requesting provider describing his/her experience with the member.

PCP/Group Name: ______________________________________________________
Provider Number________________________________________________________
PCP Contact Person: _________________________ Phone: ____________________
Signature, PCP, or Administrator: _______________________________________
Date: _________________________________________________________________

Please forward by either mail or fax to the following:

Simply Healthcare Plans, Inc.
1701 Ponce De Leon Blvd.
Coral Gables, FL 33134
Attention: Provider Operations
Phone 305-408-5700 Fax: 305-408-5765
Florida Department of Health, Practitioner Disease Report Form

Complete the following information to report the suspect or diagnosis of a disease which is reportable under Florida Administrative Code 64D-3.

Please check here if you would like more copies of this form.

Patient Information

Last Name

First Name

Date of Birth (MMDDYYYY)

Social Security Number (no dashes)

Area Code + Phone Number (no dashes)

Date of Onset (MMDDYYYY)

Disease Fatal? ☐ Yes ☐ No

Patient hospitalized? ☐ Yes ☐ No

Discharge Date (MMDDYYYY)

Hospital Name:

Medicaid Number or Insurance:

REPORT IMMEDIATELY UPON——! Initial Suspicin 24/7 by Phone

(Disease or Condition Reporting for HIV/AIDS and HIV exposed newborns: please report per forms indicated in F.A.C. 64D-3.)

☐ Amebic encephalitis ☐ Anaplasmosis ☐ Anthrax ☐ Arsenic poisoning ☐ Botulism, foodborne ☐ Botulism, infant ☐ Botulism, other/wound/unspecified ☐ Brucellosis ☐ California serogroup virus disease ☐ Campylobacteriosis ☐ Carbon monoxide poisoning ☐ Chancroid ☐ Chlamydia ☐ Cholera ☐ Ciguatera fish poisoning ☐ Conjunctivitis, in neonates ≤ 24 days ☐ Creutzfeld-Jakob disease (CJD) ☐ Cryptosporidiosis ☐ Cysticercosis ☐ Dengue ☐ Diaphragm ☐ Diphtheria ☐ Eastern equine encephalitis virus disease ☐ Ehrlichiosis ☐ Encephalitis, other (non-arboviral) ☐ Enteric disease due to Escherichia coli O157:H7 ☐ Enteric disease due to other pathogenic Escherichia coli ☐ Giardiasis ☐ Glanders ☐ Gonorrhea ☐ Granuloma inguinale ☐ Herpesvirus influenzae, meningitis and invasive disease ☐ Hensel’s disease ☐ Human papillomavirus (HPV) infection ☐ Hemolytic-uremic syndrome ☐ Hepatitis, acute A ☐ Hepatitis, acute B, C, D, E, G ☐ Hepatitis, chronic B, C ☐ Hepatitis B surface antigen positive in pregnant women or child up to 24 months ☐ Herpes simplex virus (HSV) in infants up to 60 days old ☐ HSV encephalitis in children ≤ 12 yrs ☐ Human papillomavirus (HPV) encephalitis in children ≤ 12 yrs ☐ HSV-associated lymphocytic papilloma or recurrent respiratory papillomatosis in children ≤ 6 yrs ☐ Influenza—due to novel or pandemic strains ☐ Influenza—associated pediatric mortality in persons <18 yrs ☐ Lassa poisoning ☐ Legionellosis ☐ Leptospirosis ☐ Listeriosis ☐ Lyme disease ☐ Lymphogranuloma venereum (LGV) ☐ Malaria ☐ Measles (Rubella) ☐ Melioidosis ☐ Meningitis, bacterial, cryptococcal, other mycotic ☐ Meningococcal disease ☐ Mumps ☐ Neurotoxic encephalitis ☐ Paralysis ☐ Pertussis ☐ Pneumococcal meningitis and invasive disease ☐ Poliomyelitis ☐ Poliomyelitis (Ommittis) ☐ Q Fever ☐ Rabies, animal ☐ Rabies, human ☐ Rabies possible exposure (animal bite) ☐ Rocky Mountain spotted fever ☐ Rubella (including congenital) ☐ St. Louis encephalitis virus disease ☐ Salmonellosis ☐ Scarlet fever, including paralytic shellfish poisoning (PSP) ☐ Severe acute respiratory syndrome (SARS) ☐ Shigellosis ☐ Smallpox ☐ Staphylococcus aureus, mortality ☐ Staphylococcus aureus, intermediate or full resistance to vancomycin ☐ Staphylococcus enterotoxin B ☐ Streptococcal disease, invasive Group A ☐ Streptococcal pneumoniae, invasive disease ☐ Syphilis ☐ Syphilis, pregnancy or neonatal ☐ Tetanus ☐ Toxoplasmosis, acute ☐ Trichinosis ☐ Tuberculosis (TB) ☐ Tuberculosis (TB) ☐ Typhoid fever ☐ Typhus fever, endemic ☐ Typhus fever, epidemic ☐ Vaccinia disease ☐ Varicella (chickenpox), date of vaccination: ☐ Varicella (chickenpox), date of vaccination: ☐ Varicella mortality ☐ Venezuelan equine encephalitis virus disease ☐ Vibrio cholerae, Vibrio infections ☐ Viral hemorrhagic fevers ☐ West Nile virus disease ☐ Western equine encephalitis virus disease ☐ Yellow fever ☐ Any case, cluster of cases, or outbreak not listed above that is of urgent public health significance ☐

Provider Information

Name:

Address:

City, State, Zip:

Phone: ( ) FAX: ( )

E-mail:

County Health Department Information

Phone: ( ) FAX: ( )

Medical Information

Diagnosis Date: (MMDDYYYY)

Test Conducted? ☐ Yes ☐ No

Lab Name:

Lab Test Date: (MMDDYYYY)

Lab Results:

Test Method:

Treatment Provided? ☐ Yes ☐ No

Treatment:

Medical Record Number:

Prov Hand SHP 01/2013
Section 19: INFECTION CONTROL AND PREVENTION PLAN

Infection prevention and control is the goal of Simply Healthcare Plans, Inc. 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 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 QI Program of Simply Healthcare Plans.

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 Simply Healthcare Plans 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 health care professional who, in addition to holding Medical Doctor Degree, holds a Master 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).
   - Have a sharps prevention program in place (see below).

2. **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 Plan 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.

**SHARPS PREVENTION PROGRAM:**

Simply Healthcare Plans 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 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.
- See Provider Manual for other related information.
Section 20: SAFETY AND HEALTH PROGRAM

Introduction

The Simply Healthcare Plans, Inc. 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.

Simply Healthcare Plans’ 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

Simply Healthcare Plans 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 Simply Healthcare Plans ensures that all employees have clearly written safety and health responsibilities included within their job description, with appropriate authority to carry out those responsibilities. Simply Healthcare Plans ensures that all providers maintain a program of safety in treatment locations.
Simply Healthcare Plans 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**

Simply Healthcare Plans 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 Simply Healthcare Plans 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 Simply Healthcare Plans 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**

Simply Healthcare Plans 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.

Simply Healthcare Plans 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 Simply Healthcare Plans 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

Simply Healthcare Plans believes that employee and provider network involvement in the Safety and Health Program can only be successful when sufficient training is provided that ensures an understanding of 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.