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 State of Florida to provide the health needs of Medicaid beneficiaries enrolled with our plan.

Florida Medicaid is the state and Federal partnership that provides health coverage for Florida residents with low income so that there is access to medical care for themselves and their children. To qualify for Medicaid, Florida residents must be US nationals, US citizens, permanent residents, or legal aliens, in need of health care/insurance assistance, whose financial situation would be characterized as low income or very low income. These residents also must be either pregnant, a parent or relative caretaker of a dependent child(ren) under age 19, blind, have a disability or a family member in their household with a disability, or be 65 years of age or older.

SHP offers an appropriate and accessible range of preventive, primary care, and specialty services to meet the needs of its Medicaid 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.

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 – PROVIDER HANDBOOK

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## SECTION 1
### IMPORTANT SIMPLY HEALTHCARE PLANS CONTACT INFORMATION

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations 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. 6005 &lt;br&gt;Fax number: 305-408-5765</td>
</tr>
<tr>
<td>Member Services Department</td>
<td>1701 Ponce De Leon Blvd, Suite 300 &lt;br&gt;Coral Gables, Florida 33134-4414 &lt;br&gt;Phone: 1-800-213-1133 &lt;br&gt;Fax number: 305-408-5880</td>
</tr>
<tr>
<td>Utilization Management:</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. 2271 &lt;br&gt;Fax number: 1-800-283-2117</td>
</tr>
<tr>
<td>• Referrals/Pre-Certification</td>
<td></td>
</tr>
<tr>
<td>Special Information:</td>
<td></td>
</tr>
<tr>
<td>• All medically necessary STAT/URGENT or Expedited Requests should be called to the Pre-Certification telephone queue and identified as such. Do NOT fax the request.</td>
<td></td>
</tr>
<tr>
<td>• Please provide all documentation for medical necessity determination available when making a request</td>
<td></td>
</tr>
<tr>
<td>Utilization Management:</td>
<td>1701 Ponce De Leon Blvd, Suite 300 &lt;br&gt;Coral Gables, Florida 33134-4414 &lt;br&gt;Phone: (800) 887-6888 ext. 2271 &lt;br&gt;Auth Request Fax number: 1-800-283-2117 &lt;br&gt;Clinical Information Fax number: 305-408-5882</td>
</tr>
<tr>
<td>• Care Management Services</td>
<td></td>
</tr>
<tr>
<td>Utilization Management:</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. 2271 (Request to speak with Case Management) &lt;br&gt;Fax number: 305-408-5882 (Attn: Case Management)</td>
</tr>
<tr>
<td>• Inpatient Services</td>
<td></td>
</tr>
<tr>
<td>Pharmacy 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. 5792 &lt;br&gt;Fax number: 305-408-5883</td>
</tr>
<tr>
<td>Claims Department</td>
<td>Simply Healthcare Plans, Inc. &lt;br&gt;Attn: Claims &lt;br&gt;PO BOX 21535 &lt;br&gt;Eagan, MN 55121 &lt;br&gt;Phone: 1-800-887-6888 ext. 2166</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>PsychCare <a href="http://www.psychcare.com">www.psychcare.com</a> &lt;br&gt;10200 Sunset Drive, Miami, FL 33173 &lt;br&gt;Phone: 800-221-5487 Fax number: 800-370-1116</td>
</tr>
<tr>
<td>DME</td>
<td>AllMed Services &lt;br&gt;For Authorizations call SHP: 800-887-6888-2271</td>
</tr>
<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;PCPs to call for Authorizations Phone:</td>
</tr>
<tr>
<td>Department</td>
<td>Address</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------</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, Suite 300</td>
</tr>
<tr>
<td></td>
<td>Coral Gables, Florida 33134</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-213-1133</td>
</tr>
<tr>
<td></td>
<td>Fax number: 305-408-5880</td>
</tr>
<tr>
<td>Credentialing Department</td>
<td>1701 Ponce De Leon Blvd, Suite 300</td>
</tr>
<tr>
<td></td>
<td>Coral Gables, Florida 33134-4414</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-887-6888 ext. 5734</td>
</tr>
<tr>
<td></td>
<td>Fax number: 305-408-5887</td>
</tr>
<tr>
<td>Compliance Officer</td>
<td>1701 Ponce De Leon Blvd, Suite 300</td>
</tr>
<tr>
<td></td>
<td>Coral Gables, Florida 33134-4414</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-877-253-9251</td>
</tr>
<tr>
<td></td>
<td>Fax number: 305-408-5858</td>
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</tbody>
</table>
SECTION 2
MEMBER ENROLLMENT, ELIGIBILITY, AND DISENROLMENT

Member Eligibility and Enrollment

The State of Florida has the sole authority for final determination as to eligibility for Medicaid and whether the Medicaid Recipients are mandated to enroll in a health maintenance organization as well as in Medicaid Reform. The Agency for Health Care Administration (AHCA) or its Agent reviews the Florida Medicaid Management Information System (FMMIS) and contacts all potential members, via written notification and information. The potential member has thirty (30) calendar days to select a health plan. If the member does not select a health plan, AHCA or its Agent will auto-assign the member to a health plan using a pre-established process.

Only those Medicaid Recipients who are included in the eligible population and living in a county with authorized health plans are eligible to enroll and receive services from the health plan. AHCA or its Agent shall be responsible for enrollment, including enrollment into a health plan, and disenrollment.

Effective Date of Enrollment

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

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

- Members will be effective at 12:01 a.m. on the first calendar day of the month, as determined by AHCA or its Agent
- AHCA or its Agent will send notification to members identifying the chosen or auto-assigned health plan. If the member has not chosen a PCP, the confirmation notification will advise the member that the health plan will assign a PCP.
- Mandatory Members, based on continued eligibility, will have a Lock-In period of twelve (12) consecutive months. After an initial ninety (90) day change period, Mandatory Members will only be able to disenroll from the health plan for cause.
- AHCA or its Agent will notify members prior to the Lock-In period ending date that they have the opportunity to change health plans. For those members who do not make a choice they will be deemed as having decided to remain with the current health plan.
- In the event the member has a temporary loss of eligibility, defined as less than sixty (60) calendar days, he/she will automatically be re-enrolled into the health plan where he/she was most recently enrolled.

Newborn Enrollment

Upon a SHP’s member delivery of a baby, the newborn is not automatically enrolled with the Plan. SHP will create a temporary newborn record within the system and work with the Department of Children and Families (DCF) to have an activation form completed. Once this is done, the newborn will become eligible/active with SHP.

- PCP’s are required to notify SHP within two (2) working days of the first prenatal visit and/or positive pregnancy test by completing the Pregnancy Notification Form (Refer to the Forms section at the end of the Handbook). Once this form is received, SHP will notify the designated DCF Customer Support of a member’s pregnancy.
• Hospitals are required to notify SHP when a pregnant member presents to the hospital for delivery. This notification is to be done as per the approved Plan process. Once notified, SHP will research if the newborn has an existing record on FMMIS that is waiting activation. Upon notification of a delivery, SHP will notify the Florida State Medicaid of the delivery.

• SHP will be responsible for payment of covered services for each enrolled newborn for up to the first (1st) three (3) months of life, provided the newborn was enrolled through the Unborn Activation Process. If it is determined that SHP was not notified of a member’s pregnancy and the first step of the Unborn Activation Process was not completed before the member presented to the hospital for delivery, the newborn will not be a member of SHP upon birth. As a result, SHP will not be responsible for payment of any services rendered to the newborn until such time that the newborn becomes a member of the Plan. If the Unborn Activation Process was not followed, SHP will not be responsible of covered services provided by the hospital, the pregnant member’s attending physician and the newborn’s attending or consulting physician. Providers will be required to file claims for services provided to the newborn through the Medicaid Fee-for-Service process.

Inpatient at time of Enrollment

If a member is in the hospital (acute inpatient care) at the time of enrollment with SHP, the plan with which the member was enrolled at the time of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the member enrolls effective with SHP. SHP will only be responsible for any acute inpatient admission stays or professional services for a member as of the effective date of enrollment with SHP and until the member is discharged or disenrolls, whichever comes first.

Member Eligibility

Eligibility for Medicaid is determined on a monthly basis by The Department of Children and Families (DCF), Office of Economic Self-Sufficiency. SHP’s provider contracts places 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 (contact your Provider Relations representative for further 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.

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

Please refer to SAMPLE Simply Healthcare Plans Member Identification Card:

**SAMPLE SHP MEMBER ID CARD**

**Provider Services:**
- Eligibility: 1-800-887-8888
- Authorizations: 1-800-887-8888
- Claims Status: 1-800-887-8888

**Pharmacy Inquiries:**
- 1-800-361-4542
- Claims address: Simply
- Member Services: P.O. Box 21535
- Eagan, MN 55121

**1701 Ponce de Leon Blvd, Suite 300 Coral Gables, FL 33134-4414**

**SECTION 3 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, newborn notification, member outreach information, and others.
Non-Discrimination

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

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

Access to Care

SHP is committed to ensure that members are provided timely access to care. Access standards are noted below, to ensure 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
- Render Services and Administer Benefits in accordance to Medicaid Guidelines
- 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 SimplyCaid members
  ▪ One (1) Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) for every 750 SimplyCaid members above 1,500 members
• Ensure members utilize Plan participating network providers. If unable to locate a participating provider for services required, contact Utilization Management for assistance.
• Provide preventative healthcare screening services, as per nationally recognized guidelines/protocols – see links in Section 8 of this Handbook
• Have a procedure for non-compliant members: documentation and verbal or written notification to the member
• Provide regular appointments for adult healthcare, assessments and treatment, as indicated, or upon request for those members twenty-one (21) years of age and older
• Perform physical examinations within 72 hours or immediately if required for children taken into protective custody, emergency shelter or into the foster care program by the Department of Children and Families (DCF)
• Provide Child Health Check-Ups (CHCUP) as per the approved guidelines (Refer to CHCUP section below)
• Provide immunizations as per the approved guidelines
• Participate in the Vaccines for Children (VFC) program for members eighteen (18) years of age and younger (Refer to Children’s Vaccines section below)
• Providers will administer only VFC-supplied vaccinations for all members eighteen (18) years of age and younger that are supplied free to the provider through the VFC Program
• Provide immunization information to the Department of Children and Families (DCF) upon receipt of the member’s written permission and DCF’s request, for members requesting temporary cash assistance from the DCF
• Ensure members are aware of the availability of medical non-emergency transportation and/or public transportation, where available, by contacting Member Services for assistance
• Ensure translation services are available for those members requiring translation needs, including members requiring services for the deaf, by contacting Member Services for assistance
• Ensure members are aware of available community services/resources that are available to the member by contacting Member Services or a Care Manager
• Provide access to the Plan or its designee to examine thoroughly the Primary Care offices, books, records, and operations of any related organization or entity.
• Provide access to the Plan or its designee to conduct medical record audits, as per regulatory requirements or indicated
• Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS® (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/](http://www.cdc.gov/vaccines/)

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.

**Child Health Check-Ups Program (CHCUP)**

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

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

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

- A comprehensive health and developmental history (including assessment of behavioral health status)
- A comprehensive physical exam
- Nutritional and developmental assessment
- Vision, hearing and dental screenings
- Lab tests, including testing for lead poisoning
- Appropriate immunizations
- Health education/anticipatory guidance
- Diagnosis and treatment
- Referral and follow-up, as needed
- Referral to a dentist begins at 3 years of age or earlier as medically necessary, with subsequent examinations by a dentist every 6 months, or more frequently as prescribed by a dentist or other authorized provider

Eligible children and young adults should have health check-ups at:

- Birth
- 2 - 4 days for newborns discharged in less than 48 hours after delivery
- By 1 month, 2 months, 4 months, 6 months, and 9 months
- 12 months, 15 months, and 18 months
- Once every year for ages 2 – 20 years
- Individuals may also request a Child Health Check-Up at other times if they think their child needs it
The following recommendations are based on federal guidelines that should be included in each Well Child Care examination, based on the specified age groups.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Health History and Physical Examination</th>
<th>Mental Health Assessment</th>
<th>Health Education/Anticipatory Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants (0 – 18 months)</td>
<td>✓ History ✓ Height ✓ Weight ✓ Physical Exam <em>(All of these)</em></td>
<td>✓ Gross motor ✓ Fine motor ✓ Social/emotional ✓ Nutritional <em>(Any of these)</em></td>
<td>✓ Mental health <em>(Must be addressed)</em> ✓ Injury prevention ✓ Passive smoking <em>(Either one of these)</em></td>
</tr>
<tr>
<td>Children (2 – 6 years)</td>
<td>✓ History ✓ Height ✓ Weight ✓ Physical Exam <em>(All of these)</em></td>
<td>✓ Gross motor ✓ Fine motor ✓ Communication ✓ Self-help skills ✓ Cognitive skills ✓ Social/emotional ✓ Regular physical activity ✓ Nutritional <em>(Any of these)</em></td>
<td>✓ Mental health <em>(Must be addressed)</em> ✓ Injury prevention ✓ Passive smoking <em>(Either one of these)</em></td>
</tr>
<tr>
<td>Adolescents (7 – 20 years)</td>
<td>✓ History ✓ Height ✓ Weight ✓ Physical Exam <em>(All of these)</em></td>
<td>✓ Social/emotional ✓ Regular physical activity ✓ Nutritional <em>(Any of these)</em></td>
<td>✓ Mental health ✓ Substance abuse <em>(Either one of these)</em> ✓ Injury prevention ✓ STD prevention ✓ Smoking/tobacco <em>(Any one of these)</em></td>
</tr>
</tbody>
</table>

Providers are encouraged to review the *Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook* which provides valuable information and tools, including the American Academy of Pediatrics Recommendations for Preventative Health Care. This can be viewed by going to the following internet site:


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

**Referrals**

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

**Blood Lead Level Testing**

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

**Immunizations**

Providers are encouraged to review valuable immunization information on the Department of Health and Human Services, Center for Disease Control and Preventions website, which provides recommended vaccines and schedules for children at [http://www.cdc.gov/vaccines/](http://www.cdc.gov/vaccines/).
Birth – 18 years:
Medicaid eligible members from birth through eighteen (18) years of age are eligible to receive free vaccines through the Federal Vaccine for Children (VFC) Program. SHP will reimburse the provider the administration fee for the vaccine as per their contract. Providers must bill using the appropriate assigned HCPCS procedure code to the vaccine and a modifier code, as indicated.

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

For eligible members from birth through eighteen (18) years of age, the following vaccines and combination vaccines are available free to the enrolled VFC provider through Florida's VFC Program:
- Diphtheria-Tetanus-acellular Pertussis (DTaP)
- Haemophilus influenzae type b (HIB)
- Hepatitis B (pediatric and adult)
- Human Papillomavirus (HPV)
- Influenza
- Meningococcal Conjugate (MCV4)
- Measles-Mumps-Rubella (MMR)
- Pneumococcal Conjugate (PCV7)
- Polio (IPV)
- Rotavirus
- Tetanus-Diphtheria (Td)
- Varicella

The following vaccines are available by request or for high-risk areas only through the VCF program:
- Diphtheria and Tetanus (DT-Pediatric), Pneumococcal Polysaccharide (PPV), Hepatitis A and Meningococcal Polysaccharide (MPSV4)

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

19 – 20 years
Those Medicaid members nineteen (19) through twenty (20) years of age may receive vaccines through their health care provider. SHP will reimburse the cost of the vaccine and the administration fee as per the provider’s contract.
For eligible members ages nineteen (19) through twenty (20) years of age who lack evidence of immunity (e.g., lack documentation of vaccination), or require the vaccinations, the following vaccines and combination vaccines are reimbursable:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>Meningococcal conjugate (MCV4)</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Meningococcal Polysaccharide (MPSV4)</td>
</tr>
<tr>
<td>HPV</td>
<td>Pneumococcal Polysaccharide (PPV)</td>
</tr>
<tr>
<td>Influenza</td>
<td>Td</td>
</tr>
<tr>
<td>MMR</td>
<td>Varicella</td>
</tr>
</tbody>
</table>

21 and older

SHP covers immunizations services for members who are twenty-one (21) years of age or older only when medically necessary for the member’s health (not for travel or work-related).

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 violent or abuse please contact a Nurse Case Manager at SHP’s UM Department and/or contact the Florida Department of Children and Families (DCF) at:

- **Abuse Hot Line**: To report suspected abuse, neglect or exploitation of children and elderly or disabled adults, call the toll-free number (800) 96-ABUSE (962-2873) or TDD (800) 453-5145 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, PsychCare at 1-800-221-5487
  - Contact the Utilization Management Department and ask to speak with a Nurse Case Manager;
  - View the DCF website (www.MyFlorida.com/cf_web) or contact your local DCF
  - Alcoholic Anonymous – In Dade: 305-461-2425
  - Narcotic Anonymous – In Dade: 305-620-3875

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 Care Manager in the UM Department. 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 adults, children, and adolescents who face physical, mental or environmental challenges daily that increase their health risks and ability to fully function in society. Examples of members with special needs may include, but are not limited to:

- Members with mental retardation or related conditions
- Members with serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders
- Members with disabilities resulting from years of chronic illness
- Members with certain environmental risk factors, such as homelessness or family problems, that lead to the need for placement in foster care

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

Children Medical Services (CMS)

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

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

CMS determines the medical eligibility for the program. If you have a member who may benefit from CMS services please call us at the UM Department at 1-800-887-6888 ext. 2271, or contact CMS directly at 1-800-245-4200. You may find additional information at www.cms-kids.com.

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.

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

http://www.floridahealthfinder.gov/reports-guides/advance-directives.shtml

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 Medicaid health plans.

PCP’s Request to Disenroll a Member from their Panel

A Plan physician or provider may not seek or request to terminate a member on his/her panel or transfer a member to another 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 AHCA 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.

Family Planning

Providers must encourage and make available:
- to all pregnant women and mothers to receive, and provide documentation in the medical records of, scheduled postpartum visit for voluntary family planning including discussion of all methods of contraception as appropriate.
- Counseling and services for family planning to all women and their partners.

See also Family Planning on Section 6.

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
- 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 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 AHCA and the Florida Attorney General, any and all administrative, financial and medical records and data relating to the delivery of items and services to 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.
• 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. No additional or separate right of appeal to the Agency of Health Care Administration (AHCA) is created as a result of the health Plan’s termination of the provider.

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 the Board of Managed Health Care (BMHC) and all appropriate agencies the reasons for termination.

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

Provider-Required Incident Reporting

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.

Community Outreach

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

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

SHP Responsibility

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

Permissible and non-permissible activity

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

SECTION 4

UTILIZATION MANAGEMENT DEPARTMENT

Overview

SHP’s Utilization Management (UM) Department will be responsible for the following processes:

- Notifications
- Referrals and Quick Authorization Form
- Prior Authorizations (Pre-service requests)
- 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. 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:

- Family Planning*
- Participating Office/free standing laboratory tests at labs consistent with CLIA guidelines
- Emergent transportation services
- Urgent or emergent care at participating Urgent Care centers or any Emergency Room
- County Health Departments (CHD), Federally Qualified Health Centers, Rural Health Clinics and federally funded migrant health centers when providing:
  - Vaccines
    - STD diagnosis/treatment
    - Rabies diagnosis/immunization
    - Family planning services and related pharmaceuticals
    - School health services and urgent services

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

2. Prior Authorizations:

Prior authorization (pre-service requests) allows for the use of quality, cost-efficient covered 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 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 processed within 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.

**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.

**All of the following procedures and services require Prior Plan Notification and must be provided in a SHP participating facility*:**

- Inpatient and Observation Admissions, as noted above
- Admission to any rehabilitation and skilled nursing facility
- All surgical procedures, inpatient or outpatient
The following have special reporting requirements (refer to Forms Section):

- Abortions
- Hysterectomies
- Sterilization procedures

Cosmetic or Reconstructive Surgery, including but not limited to:

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

Services and items:

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

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

Emergency Services
Emergency services are not subject to prior authorization requirements and are available to our members 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 jeopardy to the health of the member, including a pregnant woman or fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- A pregnant woman having contractions

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 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, do not know the enrollee’s PCP, or have 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-state hospitals are reimbursable when an emergency arises from an accident or illness, the health of the recipient would be endangered if the care or services were postponed until he returned to Florida or if the health of the recipient would be endangered if he undertook travel to return to Florida.

**Post-stabilization Care Services**

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

- Post-stabilization care services that were pre-approved by 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:

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

**Prior Notification for Hospital Admissions**

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

- Elective Admissions: Notification is required at least fourteen (14) calendar days prior to the scheduled procedure or admission.
• Emergency Admissions: Notification required within one (1) day of an emergency of urgent admission.
• Inpatient admission after Ambulatory Surgery: required within one (1) day of the inpatient admission.

**Inpatient Hospital Care Limits**

• Inpatient hospital care for adults age 21 and older who are Medicaid recipients is limited to forty-five (45) days per Florida state fiscal year (July 1 through June 30).
• For Plan Medicaid recipients twenty (20) years and younger, the Plan’s responsibility for inpatient hospital care is limited to forty-five (45) days per Florida state fiscal year (July 1 through June 30).
• Inpatient coverage is available via Medicaid fee-for-service for recipients under 21 who are enrolled in a Medicaid HMO and have exhausted their HMO inpatient benefits.

**Obstetrical Admissions**

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

**Dental Services in the Hospital**

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

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

**Hospice**

To qualify for the Medicaid hospice program, all recipients must:
• Be eligible for Medicaid hospice
• Be certified by a physician as terminally ill with a life expectancy of six months or less if the disease runs its normal course
• Voluntarily elect hospice care for the terminal illness
• Sign and date a statement electing hospice care
• Disenroll as a participant in a Medicaid health maintenance organization (HMO)
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.

Pregnancy

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

SHP will allow pregnant enrollees to choose in-network obstetricians as PCP’s if the obstetrician is willing to participate as a PCP.

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

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

If the provider knows the recipient is pregnant and that her unborn child does not have a Medicaid ID number, the provider may have the newborn assigned a number by sending a CF-ES 2039, Medical Assistance Referral Form to the Department of Children and Families (DCF) regional office. The forms may be downloaded at http://www.dcf.state.fl.us/publications/eforms/es2039.pdf. Or the member may call the DCF to notify them of her pregnancy and obtain the Unborn ID Number and later call SHP Member Services with the number.

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

Global Obstetric (OB) Authorizations

SHP makes every effort to identify pregnant women as early as possible for referral to the SHP Healthy Pregnancy Program and, if upon evaluation, potential high risk is identified, referral to the SHP High-Risk OB Program.

Requests for Authorizations/Referrals

- NOTE: PCP’s or obstetricians are required to notify SHP within two (2) working days of the first prenatal visit and/or positive pregnancy test by completing the Pregnancy Notification Form (refer to the Forms Section).
Upon identification of a pregnancy, the member will be referred to an OB Care Management Coordinator who will:

- Contact the member and complete an OB Risk Assessment
- Initiate referrals to the OB/GYN (Global OB Authorization) or other providers, as indicated
  - NOTE: Pregnant members are not required to see their PCP for a referral for prenatal care
- Enroll the member into SHP’s Healthy Pregnancy Program
- Refer the member to SHP’s High-Risk OB Program, if risk factors are identified

The Global OB authorization includes:

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

**Florida Healthy Start and WIC Referrals:**

The SHP OB Care Management Coordinator will assist the provider in the education of the member and assistance, if needed, to the Florida Healthy Start Program and the Women, Infants, and Children (WIC) Program.

**Newborn Deliveries:**

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

**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 prior authorization number. Written follow-up documentation of the decision will be sent to the out-of-network provider within one (1) business day from the request. The member will be liable for the cost of unauthorized services from non-participating providers.

**County Health Departments (CHD)**

- Upon receipt of a request for a physical screening of a child or adolescent from the DCF or other protective agency or shelter, the UM department will coordinate an urgent (within 72 hours, or immediately if needed) physical screening by the member’s PCP, or another participating provider if the PCP is not available.
• Claims of CHCUP screenings done while the child/adolescent was in the care and custody of DCF and was later determined to be a member of the Plan will be approved and later forwarded to AHCA.

• Emergency shelter medical screenings for members who are DCF clients will be authorized retrospectively to CHDs.

Mental Health

Mental health referrals and services are processed and determinations issued by PsychCare:

• By calling 1-800-221-5487, or
• Via the web at www.psychcare.com, or
• By fax at (305) 279-4344 - Use the PsychCare 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 PsychCare 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 PsychCare or SHP Member Services so that the care is not interrupted.

• Members can receive psychiatry services within 24 hours of release from jail, juvenile detention or other justice facility. Call PsychCare at 1-800-221-5487.

• Services include individual, group and family therapy or evaluations, treatment planning, social rehabilitation, day treatment for adults and children.

• Inpatient hospital services: up to 45 days in the hospital for inpatient admission for a mental or behavioral problem for each contract year (A contract year is July 1 through June 30).

• Inpatient Rehabilitation for Pregnant Substance Abusers: Up to twenty-eight (28) inpatient hospital days in an inpatient hospital substance abuse treatment program for pregnant substance abusers who meet certain rules. Call Member Services to find out more.

Behavioral or Mental Health Services Not Covered by SHP:

Please call the local Medicaid Office (1-800-953-0555) or the DCF office to ask how your patient can get these services under Medicaid. You may also call SHP’s Member Services to assist you.

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

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

- Members are advised to call 911 or go to the nearest emergency room if they need emergency mental 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 PsychCare at 1-800-221-5487 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.

**Requests for a Second Medical Opinion**

Second Opinion is a consultation by a physician other than the member’s Primary Care Physician, whose specialty is appropriate to the need, and whose services are obtained when the member disputes the appropriateness or necessity of a surgical procedure, is subject to a serious injury or illness, including failure to respond to the current treatment plan.

The member will be advised to contact the Primary Care Physician (PCP) and request a consultation with the necessary specialty provider. The member may select a contracted provider listed in the provider directory supplied by SHP or a non-contracted provider in the Plan’s geographic area. The UM Coordinator will contact the member’s PCP, or admitting physician if the member is in the hospital if necessary to assist in the second opinion process.

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

SHP’s physician’s professional judgment concerning the treatment of a member derived after review of a second medical/surgical opinion shall be controlling as to the treatment obligations of SHP. Treatment not authorized by SHP is at the member’s expense.

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

The Medical Director may choose to deny reimbursement rights granted as above in the event the member seeks in excess of three (3) such referrals per year if such subsequent referrals costs are deemed by SHP to be evidence that the member has unreasonably over-utilized the second opinion privilege. A member thus denied reimbursement under this section should have recourse to grievance procedures as identified in ss.408.7056, 641.495, and 641.511 F.S.
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

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

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

2. **New members:**
   - For Medicaid members voluntarily enrolling, a written prior authorization for ongoing services from FFS Medicaid will be honored for a period of ten (10) calendar days after the effective date of enrollment or until the Plan’s provider assigned to that member reviews the member’s treatment plan, whichever comes first.
   - For members assigned by the state, any written prior authorization of ongoing services will be honored for a period of one (1) month after the effective date of enrollment or until the Plan’s PCP assigned to the member reviews the member’s treatment plan, whichever comes first.

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 UM In-patient Coordinator will be responsible for working with the member, attending physician, the PCP, the hospital/facility staff, and all ancillary service providers in completing all discharge needs for the member. He/she will also identify any on-going care needs and refer, as indicated, to 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 managing 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 ongoing 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 ongoing 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 305-408-5882.

**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:

- American Academy of Pediatrics guidelines
- American College of Physicians guidelines
- Department of Health & Human Services, U.S. Preventative Services Task Force (USPSTF)
- Florida Medicaid Medical Services Coverage and Limitations Handbook
- Florida Medicaid Hospital Services Coverage & Limitations Handbook
- Florida Medicaid Handbooks
- Centers for Medicare and Medicaid Services (CMS)
- 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 5
PREGNANCY-RELATED REQUIREMENTS

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

A. Florida’s Healthy Start Prenatal Risk Screening

Florida’s Healthy Start prenatal risk screening must be offered to each pregnant enrollee as part of her first prenatal visit, as required by the State of Florida:
(1) You must use the DOH prenatal risk form (DH Form 3134), which can be obtained from the local CHD or at www.doh.state.fl.us/Family
(2) Keep a copy of the completed screening form in the member's medical record and provide a copy to the member.
(3) Submit the completed DH Form 3134 to the CHD in the county where the prenatal screen was completed within ten (10) business days of completion of the screening.
(4) Collaborate with the Healthy Start care coordinator within the member’s county of residence to assure delivery of risk-appropriate care.

In addition, SHP’s Healthy Pregnancy Program coordinators will work with you and the member to coordinate services and strive for excellent outcomes.

B. Florida’s Healthy Start Infant (Postnatal) Risk Screening Instrument

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

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

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

D. Refer all infants, children up to age five (5), and pregnant, breast-feeding and postpartum women to the local WIC office.
1. You must complete the following:
   - A completed Florida WIC program medical referral form (available at www.doh.state.fl.us/Family, click on WIC) with the current height or length and weight, taken within sixty (60) calendar days of the WIC appointment;
   - Hemoglobin or hematocrit; and
   - Any identified medical/nutritional problems.
2. For subsequent WIC certifications, coordinate with the local WIC office to provide the above referral data from the most recent CHCUP.
3. Each time you complete a WIC referral form, you must give a copy of the form to the member and keep a copy in the member's medical record.

E. Give all women of childbearing age HIV counseling and offer them HIV testing. See Chapter 381, F.S.
   1. You must offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at twenty-eight (28) and thirty-two (32) weeks.
   2. You must attempt to obtain a signed objection if a pregnant woman declines an HIV test. See s. 384.31, F.S. and 64D-3.019, F.A.C.
   3. Ensure that all pregnant women who are infected with HIV are counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (Public Health Service Task Force Report entitled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States).

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

G. All infants born to HBsAg-positive members:
   - must receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable, preferably within twelve (12) hours of birth, and shall complete the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.
   1. Test infants born to HBsAg-positive enrollees for HBsAg and Hepatitis B surface antibodies (anti-HBs) six (6) months after the completion of the vaccine series to monitor the success or failure of the therapy.
   2. Report to the local CHD a positive HBsAg result in any child age 24 months or less within twenty-four (24) hours of receipt of the positive test results.
   3. Refer infants born to enrollees who are HBsAg-positive to Healthy Start regardless of their Healthy Start screening score.

H. Report to the Perinatal Hepatitis B Prevention Coordinator at the local CHD all prenatal or postpartum enrollees who test HBsAg-positive.
   You also need to report said enrollees’ infants and contacts to the Perinatal Hepatitis B Prevention Coordinator.
   1. Report the following information – name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or estimated date of confinement, whether the enrollee received prenatal care, and immunization dates for infants and contacts.
   2. Use the Perinatal Hepatitis B Case and Contact Report (DH Form 1876) for reporting purposes.
I. Maintain all documentation of Healthy Start screenings, assessments, findings and referrals in the members’ medical records.

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

K. Nutritional Assessment/Counseling
   Supply nutritional assessment and counseling to all pregnant enrollees.
   (1) Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes;
   (2) Offer a mid-level nutrition assessment;
   (3) Provide or refer the member to individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment; and
   (4) Ensure documentation of the nutrition care plan in the medical record by the person providing counseling.

L. Obstetrical Delivery
   Use generally accepted and approved protocols for both low-risk and high-risk deliveries reflecting the highest standards of the medical profession, including Healthy Start and prenatal screening.
   (1) Document preterm delivery risk assessments in the enrollee’s medical record by week twenty-eight (28).
   (2) If you determine that the enrollee’s pregnancy is high risk, ensure that the obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and that the member progresses through the final stages of labor and immediate postpartum care.

M. Newborn Care
   Provide the highest level of care for the newborn beginning immediately after birth. Such level of care shall include, but not be limited to, the following:
   (1) Instilling of prophylactic eye medications into each eye of the newborn;
   (2) When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
   (3) Weighing and measuring of the newborn;
   (4) Inspecting the newborn for abnormalities and/or complications;
   (5) Administering one half (.5) milligram of vitamin K;
   (6) APGAR scoring;
   (7) Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen; and
   (8) Any necessary newborn and infant hearing screenings (to be conducted by a licensed...
audiologist pursuant to Chapter 468, F.S., a licensed M.D. or D.O., or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or a licensed audiologist).

N. Postpartum Care
(1) Provide a postpartum examination for the enrollee within six (6) weeks after delivery;
(2) Provide for voluntary family planning, including a discussion of all methods of contraception, as appropriate;
(3) Refer the newborn to a pediatrician for completion of CHCUP (Child Health Check Up) screenings

SECTION 6
COVERED SERVICES

Covered Services and Limitations

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

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

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

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

COVERED SERVICES INCLUDE:

Abortion - An abortion may be performed when the life of the mother would be endangered if the fetus were carried to term; this must be documented in the medical record by the attending physician stating the reason for the necessity of the abortion, or if the pregnancy is the result of rape or incest. Abortions must be documented with a completed Abortion Certification Form. Refer to the Forms Section at the end of this handbook.

Ambulance Services: Covered for emergency transportation to a hospital.
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.

Child Health Check Up (CHCUP) – see Section 3 above

Circumcisions: Routine newborn circumcisions covered up to 12 weeks of age. After 12 weeks of age, covered if medically necessary and a referral is needed.

Dental Services - Adults: Two cleanings per year. All other Adult services are covered through fee-for-service Medicaid. Members can call the Medicaid Area Office in their county to locate a participating provider.

Dental Services – Children: Covered through fee-for-service Medicaid. Members can call the Medicaid Area Office in their county to locate a participating provider.

Diabetes and Education and Supplies – When medically necessary

Durable Medical Equipment - Equipment includes but is not limited to crutches, canes, walkers, commodes, wheelchairs, oxygen and oxygen-related equipment.

Emergency Services – described in Section 4

Family Planning Services - Family Planning Services include education, information, referral, counseling, diagnostic procedures and contraceptive drugs and supplies. Members have freedom of choice in choosing a contraceptive method and the services are voluntary.

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

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

- If a member receives Family Planning services from a non-participating provider, SHP will reimburse the provider at the Medicaid reimbursement rate.

Freestanding Dialysis Facility Services - 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.

Hearing Services - Include examinations and evaluations necessary for the furnishing of one standard hearing aid per ear every three years, hearing evaluations, hearing aid devices and hearing aid repairs.

Home Health Care - Includes intermittent or part-time nursing services (R.N. or L.P.N.), personal care services by a home health aide, if there are skilled needs, and medical items, with limitations. It does not include homemaker services, Meals on Wheels, companion, social services or a sitter.
All services must be provided by a participating provider. The PCP must notify SHP of services requiring home health care. There are a limited annual amount of visits.

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

**Immunizations** – See Section 3 above

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

**Inpatient Hospital Services** – See Section 4. Rehab inpatient care is also covered as inpatient hospital. SHP is responsible for professional charges beyond the 45 days limit.

**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.

**Lead Screening** – required as per Federal regulations. Please see Section 3 above.

**Maternity Services** – see Pregnancy Related Requirements on Section 5

**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 PsychCare in Section 1.

**Outpatient Services** Outpatient services provided in an outpatient hospital setting. All require prior authorization.

**Over the Counter (OTC)** - SHP gives each household a designated amount for over-the-counter items not to exceed $25.00 per household, per month. This benefit is limited to a list nonprescription drugs and other items.

**Physician Services** - Includes all services by participating providers when necessary for preventive, diagnostic, or to treat a particular illness. Exclusions: experimental procedures and cosmetic surgery. These services include Advanced Registered Nurse Practitioners (ARNP), physician assistants (P.A), (under supervision of a licensed physician or OB-GYN), Ambulatory surgical centers, Podiatrists, Federally Qualified Health Centers, Community health departments, Rural health clinic services, Birth centers (for non high-risk pregnancies), certified midwives working in coordination with an OB GYN, Chiropractors, Psychiatrists.

**Podiatry Services** - when provided by a participating podiatrist. No referral needed except for inpatient, select outpatient services, and outpatient surgeries.

**Prescribed drugs** - Drugs currently covered by the Medicaid program, when ordered by a participating provider and supplied by a licensed participating pharmacy.
Inpatient Rehabilitation for Pregnant Substance Abusers:
Up to twenty-eight (28) inpatient hospital days in an inpatient hospital substance abuse treatment program for pregnant substance abusers who meet ISD Criteria with Florida Medicaid modifications, as specified in InterQual Level of Care Acute Criteria-Pediatric and/or InterQual Level of Care Acute Criteria-Adult, the most current edition, for use in screening cases admitted to rehabilitative hospitals and CON-approved rehabilitative units in acute care hospitals.
Inpatient rehabilitation for non-pregnant substance abusers is not a covered benefit.

Sterilization - Non-therapeutic sterilization must be documented with a completed Sterilization Consent Form. (Refer to the Forms Section on this Handbook) as per Federal and State regulations. The form may also be downloaded from the AHCA site at [http://portal.flmmis.com/FLPublic/Portals](http://portal.flmmis.com/FLPublic/Portals), clicking at the Medicaid Provider Reimbursement Handbook.
Sterilization procedures performed in the inpatient hospital, outpatient hospital and ambulatory surgical center settings are for the primary purpose of rendering a recipient (male or female) incapable of reproducing and are voluntary procedures reimbursable by Medicaid.
The following criteria must be met: The recipient must be at least 21 years old at the time of signing the State of Florida Sterilization Consent Form; must be mentally competent and not institutionalized in a correctional, penal, rehabilitation facility or a facility for mental diseases; and a State of Florida Sterilization Consent Form must be correctly completed and signed at least 30 days prior to sterilization, and a copy must be submitted with the physician claim for reimbursement. Abbreviations on the consent form are not acceptable. No other form is acceptable.
The member must wait at least 30 days after signing the consent form to have the operation, except when premature delivery or emergency abdominal surgery takes place at least 72 hours after the consent is obtained. The consent for sterilization cannot be obtained while the plan participant is in the hospital for labor, childbirth, abortion, or under the influence of alcohol or other substances. The consent is effective for 180 days from the date the consent form is signed by the member. If 180 days have passed before the surgery is provided, a new consent form must be signed.

Therapy Services - physical, respiratory, occupational and speech therapies - medically necessary therapy services that are provided to Medicaid recipients under the age of 21.
Speech Language Pathology services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings to recipient’s age 21 and older are also covered. These are the only services in the therapy program that Medicaid reimburses for adults.
Adults are covered for physical and respiratory therapy under the Outpatient Hospital Services program.

Transplants - Please send a completed Referral and Authorization form if you need to refer a member for a transplant. SHP covers bone marrow, cornea, intestinal/multivisceral, kidney, and pancreatic transplants and all pre and post transplant care. (Fee-for-service Medicaid covers heart, liver and lung; for these three types of transplant, the member needs to disenroll from the Plan. The member may reenroll 1 year later).

Transportation Non Emergency – covered by Medicaid, not SHP. Members need to call 1-866-726-1457 for information in Miami-Dade county.

Vision Services - Medically necessary fitting, dispensing, repair and adjustment of eyeglasses and follow up examinations by an optometrist are covered as well as eyeglasses and contact lenses* limited to no more than two pairs of glasses per member, per year or a pair of specialized contact lenses per year, if medically necessary, and prosthetic eyes. Visual exams are covered, limited to a visual examination.
*Contact lenses are only covered for the following conditions:
• Unilateral aphakia or bilateral aphakia, but not pseudophakia • Keratoconus • Irregular cornea or irregular astigmatism (does not apply if the recipient has had previous refractive surgery) • Significant,
symptomatic anisometropia • Refractive errors that are + or – 7.00D and over, any meridian, either eye, spectacle prescription; or • Nystagmus, congenital or acquired but not latent monocular, where there is significant improvement of the visual acuity with contact lens wear regardless of the refractive error, astigmatic status, or natural lens status.

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.
- 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 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
- 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
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

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
- 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
- Reporting to the health care provider whether they comprehend a contemplated course of action and what is expected of them
- 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

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.

Providers are encouraged to review valuable information, educational materials and forms available through the AHCA Website for Advance Directives – The Patient’s Right to Decide at: http://www.floridahealthfinder.gov/reports-guides/advance-directives.shtml

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.

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**Clinical Practice Guidelines Reference Guide**

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<td>U. S. Dept. of Veterans Affairs, Reviewed/ Updated Nov. 2009</td>
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**Additional links for reference:**

**LINKS TO DIABETES GUIDELINES**
Standards of Medical Care in Diabetes – 2012:
[http://care.diabetesjournals.org/content/35/Supplement_1/S11.full](http://care.diabetesjournals.org/content/35/Supplement_1/S11.full)

**LINKS TO HIV/AIDS GUIDELINES**
The guidelines include the ones issued by national organizations and can be accessed at:

[http://www.faetc.org/Treatment/](http://www.faetc.org/Treatment/)
[http://www.samhsa.gov/hiv/docs/MHCareAIDS-PracticalGuide.pdf](http://www.samhsa.gov/hiv/docs/MHCareAIDS-PracticalGuide.pdf) --- Chapter 5

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Prov Hand SHP Jan 2013
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), 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 and 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 & Medicaid Services (CMS), Plan member and organizations conducting accreditation audits

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

**Medical Records Audits and Compliance**

In order to comply with regulatory and accreditation requirements, the SHP Quality Improvement 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 IMPROVEMENT

Overview

SHP maintains an active Quality Improvement Program (QIP) that provides structure and processes for our ongoing commitment to provided and 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:
  - SHP’s Healthy Pregnancy Program;
  - SHP’s High-Risk Pregnancy Program;
  - Children’s Wellness Program;
  - Diabetes Management Program;
  - CHF Management Program;
  - Chronic Care Improvement Program;
  - Chronic Kidney Disease Program.
- Preventative Care and Clinical Practice Guidelines
- Measurement of Clinical and Service Quality; HEDIS, CAHPS®, Provider Satisfaction Survey, Member Satisfaction Survey, and key quality metrics
- Care Management and Model of Care for Special Needs Plan (dually eligible) members

SHP offers disease management programs to help you understand and manage a chronic health condition you may have. Our team of health care professionals, including your PCP, will help you with your health care needs. They will arrange for home health care and medical supplies needed to manage your condition, if needed. For more information on disease management programs available, please call Member Services.

Other Resources for you to assist our members
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 QI Department will assess, on an ongoing basis, the minimum guidelines of care required by regulatory agencies and accreditation organizations for medical record review, health screening and high-risk diagnoses; a representative from the Plan’s QI Department, or assigned Plan designee, will contact the provider’s office to schedule an appointment to review the items in the office. Upon completion of the review, the provider will have an exit meeting with the reviewer to have the findings presented to him/her. At that time any deficiencies found during the review will be outlined so as to assist the provider in making any necessary corrections. A Correction 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 CRC or Peer Review Committee recommendations and actions, including the ones resulting in filing a report to the Florida Division of Medical Quality Assurance, Department of Health and the NPDB.

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 or a designee chairs the Peer Review Committee. Its membership is drawn from the provider network and includes peers of the provider being reviewed. All peer review activities and data collected are confidential pursuant to Florida State law.

The Plan supplies the providers with a summary of the rights in the hearing in accordance with the 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, the 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.
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 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
  - Women’s Health Care Providers
  - OB/GYNs
  - 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 Review 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 such as medical license, education and training, NPDB, etc., 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)

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.

Medicaid Program

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

Provider’s Right to Review

Providers have the right to review 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
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
PROVIDER COMPLAINTS

The SHP’s appeals rights provide the SHP network providers the opportunity to express dissatisfaction about original authorization/referrals and claims determination and request a re-review and re-determination on the initial adverse decision made, as well as about any other administrative complaints they may have.

Complaints: SHP has dedicated staff for providers to contact the Plan via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems. The Sr. Provider Operations Coordinator will be specifically designated to receive and process provider complaints.

- SHP provides a summary of the provider complaint system policies and procedures at no cost to out of network providers, upon request by calling the SHP Provider Relations Department at 1-800-887-6888 ext 6005. This summary includes the plan’s process for obtaining the plan’s policies and procedures on SHP’s website.
- Providers can file their complaint in writing via electronic mail, regular mail or in person.
- Electronic mail should be sent to: ProviderRelations@Simplyhealthcareplans.com

Providers are encouraged to first communicate any concerns or dissatisfaction about an 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.

After hours, an electronic voice messaging system will record provider complaints. The provider should briefly explain the issue; give his/her name, phone number and provider ID number on the message. The Provider Operations Coordinator will acknowledge receipt of the complaint within 5 business days either orally or in writing.

Phone calls and their resolution will be documented, coded and tracked by category and reports will be generated and reviewed monthly by the Director of Provider Relations. Reports will be presented to the Quality Improvement Committee.

Grievance: The SHP provider grievance process provides the SHP network providers the opportunity to express dissatisfaction about an SHP service/administrative issue. A complaint is not considered formal until it is written and signed by the provider. All grievances must be submitted within 60 days from the date of incident or event.

Appeal: The SHP appeals rights provide the SHP network providers the opportunity to appeal an authorization/referral or claim determination and request a review and redetermination on the initial adverse decision made. Please note the timeframes described below, as failure to timely appeal the denial and nevertheless provide the service at issue may result in denial of the claim for that service based on your failure to properly appeal the initial denial.

The member may not be billed for any services rendered during the denied days, because the member is a Medicaid recipient.

Submission of Formal Grievances and Appeals:

Providers are encouraged to first communicate any concerns or dissatisfaction about an 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. After hours, an electronic voice
messaging system will record provider complaints.

1. All SHP providers have the right to submit a formal written appeal to SHP:
   - within 45 calendar days from the denial disposition on a referral/authorizations/grievance adverse determination;
   - within 365 calendar days from the date of service for a claim adverse decision
2. A provider’s written grievance and/or appeal must be forwarded to the SHP Provider Appeals Coordinator at the following address:

   Simply Healthcare Plans, Inc.
   1701 Ponce De Leon Blvd, Suite 300
   Coral Gables, Fl 33134-4414
   Toll Free Number: 1-800-213-1133
   Attn: Provider Appeals Coordinator

3. Provider grievances and appeals are handled by the Provider Appeals Coordinator and are reviewed with the corresponding and designated department head.
4. All provider complaints are investigated using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the Plan’s written policies and procedures.
5. SHP’s Director of Provider Relations, and the Chief Operating Officer and/or Chief Medical Officer if appropriate, are involved in the provider complaint process, and have authority to require corrective action plans.
6. Upon the receipt of the provider grievance/appeal letter, a provider grievance acknowledgement letter will be forwarded to the provider within five (5) working days from the receipt of the document.
7. A resolution to the provider’s appeal will be rendered and communicated to the provider in writing within a sixty (60)-day period from the receipt of the provider appeal or grievance. The letter will include information on filing a Level II appeal, should the provider not be satisfied with the decision.
8. Grievance extensions: If the review of the grievance (excluding appeals) involves the collection of information outside the service area or from a non-participating provider, an additional 30 days extension is allowed, with prior notification to the provider.
9. The time limitations requiring completion of the grievance review shall be tolled after SHP has notified the provider in writing that additional information is required. Upon the receipt of the additional information required, the time frame for completion of the grievance process shall resume.
10. For appeals/grievances requiring a re-review of clinical records, a Medical Director or consultant other than the one who made the initial review will process the appeal and corresponding documents and render a determination.
11. The provider may request a Second Level Appeal, which includes a Grievance Committee Hearing. The provider has 10 (ten) working days from the receipt of the initial grievance/appeal determination to request a Grievance Committee Hearing. Such request will be acknowledged by the Plan within 5 (five) working days.
12. The Plan will advise the provider in writing of the date, time, and place of the Grievance Committee meeting. The Committee includes SHP-credentialed providers not involved with the original adverse determination. All documentation must be gathered and presented to the Committee within sixty (60) calendar days from the request for the second appeal.
13. The provider has the right to be represented by an attorney or other person of their choice. 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.
14. SHP will send the provider a disposition letter within ten (10) working days from the date of the Committee meeting, and never to exceed 60 calendar days from the request for a Grievance Committee Hearing.
15. The review process at all levels includes SHP’s Clinical Guidelines that incorporate the Florida Medicaid Program Guidelines.
16. There is no further appeal for the decision of the second level appeal.

The Grievance and Appeals process observes all HIPAA privacy standards for all member information.
SECTION 14
MEMBER GRIEVANCES AND APPEALS

Overview

An appeal is a request for review of an action taken by or on behalf of the Plan. The member or a provider, acting on behalf of the member and with the member’s written consent, may file an appeal. Examples of actions that can be appealed include, denial or limited authorization of a requested service, including the type or level of service, the reduction, suspension or termination of a previously authorized service, the denial, in whole or in part, of payment for a service, or the failure to provide services in a timely manner, as defined by the state.

A grievance is any complaint or dispute, other than one that involves a Plan determination, expressing dissatisfaction with any aspect of the operations, activities or behavior of SHP or its providers, regardless of whether remedial actions can be taken. Grievances may include, but are not limited to: complaints regarding the timeliness, appropriateness, access to and/or setting of a provided item. The member, his or her appointed representative or the enrollee’s physician with written consent, in the form of an Appointed Representative document (AOR), of the member, may file a grievance on the member’s behalf.

Member Grievance and Appeals Process

Members may file a grievance by contacting SHP’s Member Services toll-free at 1-800-213-1133 between the hours of 8:00 AM and 7:00 PM Monday through Friday, except for state holidays. They may also submit their grievance in writing to:
Simply Healthcare Plans, Attn: Member Services
1701 Ponce De Leon Blvd, Suite 300, Coral Gables, Florida 33134-4414

Grievances must be filed within one year (365 calendar days) after the date of the occurrence that initiated the grievance.

Members may also file an appeal when they receive notice of an adverse determination. You may assist the member in the appeals process with the member’s permission; you may do it over the phone but it must be followed by a letter. The appeal letter must be sent within 30 (thirty) days of the denial to the same address above.

Members will be offered with reasonable assistance in completing forms and completing other procedural processes, which includes translation services for members with limited English proficiency and communication assistance services for those who are hearing-impaired.

The member or his authorized representative will be allowed the opportunity before and during the appeals process to examine the case file, including medical records, and any other material to be considered during the process.

SHP will review the appeal and notify the member of the Plan’s decision no later than 45 (forty five) calendar days from the date the appeal letter was received by the Plan. If the appeal was initially by telephone, the 45-day-count starts on the day of the verbal appeal. The appeal process timeframe may be extended up to fourteen (14) calendar days if the member voluntarily agrees to the extension.

To request continuation of services while the appeal is in process:
At any time during the grievance and appeal process members have the right to:
• request a Medicaid Fair Hearing
• appear in person and/or appoint a representative to act and speak on their behalf at any point in the grievance and appeals process
• request to receive benefits while the hearing is pending. They can request to continue to receive benefits by calling our Member Services Department at 1-800-213-1133. The member may have to pay for the services if the Medicaid Fair Hearing upholds the Plan’s action.

While SHP is reviewing the appeal or grievance, the member or someone authorized by the member, like you or, have the right to request a Medicaid Fair Hearing. You or the member may also request this hearing if the member is not satisfied with our decision on the appeal. SHP will not hold it against you or the member if this type of Hearing is requested.

If you or the member decide to request a Medicaid Fair Hearing it must be done it within ninety (90) calendar days of receiving SHP’s decision letter.

The member, or you on behalf of the member, and with his/her written authorization may request a Medicaid Fair Hearing by sending a letter to:
Department of Children and Families
Office of Appeals Hearings
1317 Winewood Blvd., Building 5, Room 255
Tallahassee, FL 32399-0700
You may call the Medicaid Fair Hearing Department at 1-850-488-1429.

By having a Fair Hearing, the member gives up the right to have his/her case reviewed by the Subscriber Assistance Program.

A provider or a member’s authorized representative may request from the Plan, on the member’s behalf, that the service being appealed be continued while SHP processes the appeal. It must be requested in writing, within 10 (ten) business days of our denial/adverse decision or within 10 (ten) business days of the intended effective date of the action, whichever is later. This is only when the appeal involves:
1. the termination, suspension or reduction of a previously authorized course of treatment,
2. the services were ordered by an authorized provider,
3. the original period covered by the original authorization has not expired, and
4. the enrollee requests extension of benefits.

If SHP continues or restarts the benefits while the appeal is pending, the benefits will continue until one of the following occurs:
• The member withdraws the appeal;
• Ten (10) business days pass after SHP sends the member the notice of adverse resolution of the appeal, unless the member has requested a Medicaid Fair Hearing with continuation of benefits within those ten days;
• The Medicaid Fair hearing office issues an adverse decision to the member;
• The time period or service limits of a previously authorized service have been met.

If the final resolution of the appeal is adverse to the member and the Plan’s action is upheld, SHP may recover the cost of services furnished solely because of the continuation of benefits requirement.

The member may have to pay for the cost of the benefits if the Medicaid Fair Hearing upholds SHP’s action. If the Medicaid Fair Hearing reverses the Plan’s action, SHP will authorize the disputed services promptly and pay for those services.
Written and signed acknowledgement of the grievance/appeal is sent to the member within five (5) calendar days of receipt of the grievance/appeal by the Plan.

All issues that are related to an adverse clinical determination and/or appeal of a coverage decision are referred to SHP’s UM Department to review and make recommendations regarding the medical necessity aspects of the case and a person(s) not involved in the previous decision-making process will review the grievance or appeal to determine the resolution:

- With appeals that involve clinical services not related to a medical determination (i.e., benefit limitations), health care professionals with the appropriate expertise will conduct the review.
- For appeals that involve medical services a board-certified Plan Medical Director or consultant who was not involved with the initial determination will review the appeal and make the determination.

SHP will ensure that all grievance decisions are made within the state established time-frames not to exceed ninety (90) calendar days from the date the initial grievance was received by the Plan. The grievance process timeframe may be extended up to fourteen (14) calendar days if the member voluntarily agrees to the extension.

If a member is not satisfied with the grievance or appeal decision rendered by SHP they may request a review by the Subscriber Assistance Program (SAP):

Agency for Health Care Administration, Subscriber Assistance Program
Building 1, MS # 26, 2727 Mahan Drive, Tallahassee, FL 32308
Phone number 1-888-419-3456

The member will have one year (365 calendar days) from the receipt of the Plan’s decision notification to request a review. The right to a SAP review is forfeited if the member files for a Medicaid Fair Hearing of their case.

**Expedited Reviews**

Expedited Reviews are completed as promptly as the medical condition requires, but a final determination must be made within seventy-two (72) hours after the request was received by the Plan. Oral notice will be given to the member by close of business day of the disposition.

Criteria for a review to be expedited:
1. All grievance and appeal requests concerning inpatient admissions, continued length of stay, immediate care issues, or services for members who have received emergency services but have not been discharged from the facility.
2. Appeals in which the time for a standard, non-expedited appeal would seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function.

If the health plan denies the request for an expedited appeal, it shall immediately transfer the appeal to the timeframe for standard resolution and so notify the member. SHP will ensure that no punitive action is taken against a provider who requests or supports a request for an expedited appeal.
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 Medicaid 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

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:

3. Member’s name, date of birth, sex and ID number
4. Date(s) of service, place of service(s) and number of days or units, if applicable
5. Provider tax identification and NPI number
6. ICD-9 diagnosis codes by specific service to the highest level of specificity
7. Current CPT, revenue and HCPCS procedure code(s) with modifiers is appropriate
8. Billed charges per service(s) provided and total charges
9. Provider name and address, signature, and phone number
10. Information about other insurance coverage, Workers’ Compensation, accident or auto information, if available
11. Attach a detail description of the service or procedure for claim submitted with unlisted medical or surgical CPT or other revenue codes
12. 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.

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

Filing a Claim Electronically

Providers submitting claims electronically should receive an acknowledgement from 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 theretofore

Clean Claim

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

Timely Claims Processing and Payment

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

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 Medicaid reimbursement rate established for the hospital or provider.

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

Coordination of Benefits

Coordination of Benefits (COB) is the process used to process 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 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 at 1-877-253-9251.

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. 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, Bureau of Medicaid Program Integrity audits and investigates providers suspected of overbilling or defrauding the Florida Medicaid Program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation to the Medicaid Fraud Control Unit. Program Integrity may also originate an investigation due to a complaint being filed.

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, like a carrier, other claims processor, or state Medicaid program.

   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 Medicaid Services (CMS) is the Departmental component responsible for implementing and enforcing the other HIPAA regulations.
SECTION 17
SIMPLY HEALTHCARE PLANS FORMS

1. Referral and Authorization Form
2. Quick Authorization Form
3. Psych Care Referral Form
4. Pregnancy Notification Form
5. State of Florida Acknowledgment of Receipt of Hysterectomy Information
6. State of Florida Exception to Hysterectomy Acknowledgement Requirement Form
7. Newborn/Unborn Activation Form - AHCA Form 5240-006
8. Abortion Certification Form
9. Incident Report Form
10. Sterilization Consent Form - English
11. Sterilization Consent Form – Spanish
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: Medicaid ______ 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: __________

Phone Number: __________________________ Fax #: __________________

Address: __________________________________________________________

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
# MEDICAL / BEHAVIORAL COMMUNICATION FORM

<table>
<thead>
<tr>
<th>Date: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name: ___________________</td>
</tr>
<tr>
<td>Healthplan: ____________________</td>
</tr>
</tbody>
</table>

## REFERRAL REASON

- ________________________________________________________________________
- ________________________________________________________________________
- ________________________________________________________________________
- ________________________________________________________________________
- Referring Nurse/Case Manager: __________________
  - Phone No.: __________________ Fax No.: ______________

## RESPONSE

<table>
<thead>
<tr>
<th>Contact Nurse/Case Manager: __________________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone No.: __________________ Fax No.: ______________</td>
</tr>
</tbody>
</table>
- ________________________________________________________________________
- ________________________________________________________________________
- ________________________________________________________________________
- ________________________________________________________________________

**Please fax to:**
Psychcare at 305.279.4344

Healthplan Name: ______________________ at Fax No.: __________________
Pregnancy Notification Form

PLEASE COMPLETE AND FAX TO SHP AT 1-800-283-2117
WITHIN 2 WORKING DAYS OF THE FIRST PRENATAL VISIT

MEMBER’S DEMOGRAPHIC INFORMATION

Last name:__________________ First Name_______________ Maiden name___________________

SHP ID #__________________ SSN _____ - - - ______ Medicaid ID #:__________________ D.O.B._______

Address:____________________________ City_________________ State____ Zip code___________

Phone:_________________ Mobile or other phone #:_________________ Preferred language:_________________

Gravida___ Para___ LMP_____ EDC ___ Blood type ___ Date of last birth___ Ectopic pregnancies?___

MEDICAL INFORMATION REGARDING OB RISKS - Please check all that apply:

<table>
<thead>
<tr>
<th>Current Pregnancy</th>
<th>Previous Pregnancies</th>
<th>N/A ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes ___</td>
<td>Diabetes ___</td>
<td></td>
</tr>
<tr>
<td>Hypertension ___</td>
<td>Hypertension ___</td>
<td></td>
</tr>
<tr>
<td>Smoking ___</td>
<td>Pre-eclampsia ___</td>
<td></td>
</tr>
<tr>
<td>Hyperemesis ___</td>
<td>Incompetent cervix___</td>
<td></td>
</tr>
<tr>
<td>Multiple pregnancy___</td>
<td>Placenta previa___</td>
<td></td>
</tr>
<tr>
<td>Immunosuppressed___</td>
<td>Immunosuppressed___</td>
<td></td>
</tr>
<tr>
<td>Preterm labor___</td>
<td>Pre-term labor ___wks.</td>
<td>Pre-term delivery ___wks.</td>
</tr>
<tr>
<td>ETOH or drugs ___</td>
<td>HIV testing? ___</td>
<td>HIV counseling?____</td>
</tr>
<tr>
<td>Cervical or uterine anomalies ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other _____________</td>
<td>Prev. spontaneous abortion ___wks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical/Social Problems:

Asthma ___ Heart disease___ Neurologic illness___ Renal disease___ Anemia___ Domestic violence___

STD’s __________________________

Healthy Start Referral done? ___ WIC Referral done? ___

Comments or other pertinent information________________________________________________

_________________________________________________________________________________

OB-GYN/MIDWIFE INFORMATION

Provider’s Name:_________________ Telephone #:_______________ Fax #_______________

Office contact name:_________________________

Date of first prenatal appointment:_______________

Referring provider:_________________ Referring provider phone #:_________________

Please review your Provider Handbook for all Pregnancy Requirements; the Healthy Start Risk Screening must be completed at the first prenatal visit and WIC referral must be offered. Please fax copies of all completed forms to SHP OB Coordinator at 1-800-887-6888 ext. 5882. Please advise the member to contact DCF for notification of her pregnancy and obtain the Unborn ID number, and later call SHP with this number.
STATE OF FLORIDA
HISTERECTOMY
ACKNOWLEDGMENT FORM

ACKNOWLEDGMENT OF RECEIPT OF HISTERECTOMY INFORMATION

PART A - PHYSICIAN STATEMENT:

_________________________________________ (PRINT PHYSICIAN’S NAME)  ____________________________________ (PROVIDER NO.)
understand that the Florida Medicaid Program shall not allow payment for a hysterectomy unless it is performed pursuant to the federal requirements stated in 42 CFR 441, Subpart F and accordingly Parts A and B of this form are being completed.

The hysterectomy to be performed is not solely for the purpose of rendering the below mentioned recipient permanently incapable of reproducing nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The nonelective hysterectomy is therefore being performed for the following medical reasons:

__________________________________________ (ENTER DX AND EXPLAIN IF NECESSARY)

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

PHYSICIAN’S SIGNATURE  ______________________ DATE

PART B - PATIENT STATEMENT:

It was explained verbally before surgery and in writing by completion of this form to:

__________________________________________ (PRINT: RECIPIENT’S FIRST NAME, INITIAL, LAST NAME, MEDICAID I.D. #)

that the hysterectomy to be performed or which was performed would render her permanently incapable of reproducing.

__________________________________________ PATIENT’S SIGNATURE OR MARK  ______________________ DATE

Patient's mark must be witnessed by her representative.

__________________________________________ INTERPRETER’S SIGNATURE, WHEN NECESSARY  ______________________ DATE

DISTRIBUTION OF COPIES:

ORIGINAL - Retain in patient’s medical record at physician’s office.
1 COPY - To patient.
Other copies as required - See note below.

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

HAF 07/1999
STATE OF FLORIDA ABORTION CERTIFICATION FORM

SECTION I
1. Recipient’s Name:________________________________________________

2. Address:________________________________________________________

3. Medicaid Identification Number:______________________________________

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

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

☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.

☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

I have documented in the patient’s medical record the reason for performing the abortion; and I understand that Medicaid reimbursement to me for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5. ________________________________ 6. ______________________________
   Physician’s Name                                             Physician’s Signature

7. ________________________________ 8. ___________________________
   Physician’s Medicaid Provider Number                Date of Signature
INCIDENT REPORT FORM - PRIVILEGED AND CONFIDENTIAL

Please complete the following:

Product: (circle one) Medicaid 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
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■
I have asked for and received information about sterilization from _____________________________. When first asked _____________________________.

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any benefits or benefits from programs receiving Federal Funds, such as A.F.D.C. or Medicaid. I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as _____________________________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____________________________.

I, _____________________________, hereby consent of my own free will to be sterilized by _____________________________.

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: _____________________________.

I am a representative of the Department of Health and Human Services, or Employer of programs or projects funded by the Department, but only for determining if federal laws were observed. I have received a copy of this form.

______________________________
Signature

______________________________
Date

______________________________
Month Day Year

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (check box)

Ethnicity:
- Hispanic or Latino
- Not Hispanic or Latino

Race (mark one or more):
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White

■ PHYSICIAN’S STATEMENT ■

Shortly before I performed sterilization operation upon

name of individual _____________________________ on _____________________________.

declared under the nature of the sterilization operation _____________________________

the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I explained the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

______________________________
Signature of person obtaining consent

______________________________
Date

______________________________
Facility

______________________________
Address

______________________________
Name

______________________________
Physician’s Signature

______________________________
Date

HHS-687 (11/2006)
CONSENTIMIENTO PARA LA ESTERILIZACIÓN

NOTA: LA DECISIÓN DE NO ESTERILIZARSE QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO CAUSARÁ EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO QUE LE SEA PROPORCIONADO POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Yo he solicitado y he recibido información sobre la esterilización. Cuando inicialmente solicite esta información, me dijeron que la decisión de ser esterilizado es completamente mía. Me dijeron que yo puedo decidir no ser esterilizado. Si decidí no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderá ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F.D.C. o Medicare, que recibió actualmente o para los cuales será elegible.

ENTENDO QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E INVERSO, YO HE DECIDIDO QUE NO QUIERO QUEMAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HUEVOS.

Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitan que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizado.

Entiendo que será esterilizada por medio de una operación conocida como:

Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizado no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el:

(dia, mes, año)

por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por (nombre)

por el método llamado

Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.

También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a:

Recepción del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si han cumplido las leyes federales.

He recibido una copia de esta Forma.

(firma)

(dia, mes, año)

Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo: (Definición de raza y origen étnico)

Oriental/etnico: 
□ Hispano o latino □ Indígena americana o inicia de Alaska
□ Otro □ No hispano o latino

Raza (marque según aplica):
□ Asiático
□ Negro o afroamericano
□ Natural de Hawai o otras islas del Pacífico
□ Blanco

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada:

He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada por el individuo que ha otorgado este consentimiento. También le he leído a él/ella la Forma de consentimiento en idioma ( ) y le he explicado el contenido de esta forma. A mi mejor saber y entender, él/ella ha entendido esta explicación.

(firma del intérprete)

(firma)

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■ DECLARACIÓN DE LA PERSONA QUE OSTEINE CONSENTIMIENTO ■

Antes de que (nombre de persona)

firmara la Forma de Consentimiento para la Esterilización, le he explicado a él/ella los detalles de la operación para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento.

Le aconsejé a la persona que será esterilizada que haya disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente.

Le expliqué a la persona que será esterilizada que pueda retirar su consentimiento en cualquier momento y que ello no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Él/ella ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

(firma de la persona que obtiene el consentimiento)

(fecha)

■ DECLARACIÓN DEL MÉDICO ■

Previo a realizar la operación para la esterilización a (nombre de persona esterilizada/o)

Le expliqué a él/ella los detalles de esta operación para la esterilización del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le aconsejé a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le explicó que la esterilización es diferente porque es permanente.

Le informé a la persona que será esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o algún beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Él/ella ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

(firma del médico)

(fecha)