1 Administration .................................................................................................................. 6

Section 1 – Overview ........................................................................................................ 6

Introduction ....................................................................................................................... 6

History ................................................................................................................................. 6

Purpose of this Manual ...................................................................................................... 6

Protocols and Guidelines ................................................................................................. 6

Key Contact Information .................................................................................................. 7

Provider Tools .................................................................................................................... 7

Translation Services .......................................................................................................... 7

IVR (Integrated Voice Response System) ........................................................................... 8

Forms & Reference Documents ......................................................................................... 8

Designated Liaison ............................................................................................................. 8

Member Responsibility ...................................................................................................... 8

Direct Access and Cost-Sharing ....................................................................................... 8

Marketing ............................................................................................................................ 8

Compliance and Ethics Program ....................................................................................... 8

2 Medicaid ............................................................................................................................ 9

Section 2 – Medicaid Program .......................................................................................... 9

Medicaid Program ............................................................................................................. 9

Florida Agency for Health Care Administration’s Medicaid Coverage and Limitations Handbook ........................................................................................................... 9

Medicaid Fraud and Abuse Complaint Form .................................................................... 9

Provider Subcontractor Responsibilities ......................................................................... 10

Continuity of Care in Enrollment ...................................................................................... 10

Emergency Service Responsibilities .............................................................................. 10

Requirements Regarding Background Screening ............................................................. 11

Cultural Competency ........................................................................................................ 11

Community outreach and marketing activities: ................................................................. 13

Florida SHOTS/Healthy Kids ............................................................................................ 14

Important Information for Medicaid Members ................................................................. 14

Healthy Behaviors Program: ............................................................................................ 14

Listing of Medicaid Covered Services ............................................................................. 14

3 Provider Participation ..................................................................................................... 23

Section 3 – Provider Programs and Responsibilities ......................................................... 23

Provider Selection Criteria ............................................................................................... 23
Section 8 – Quality Improvement .................................................. 40
  Quality Improvement .................................................................. 40
  HEDIS™ ....................................................................................... 40
  Medical Quality Performance Measure ....................................... 41
  Risk Management Program ......................................................... 43

Section 9 – Fee Schedule Maintenance & Reimbursement Determinations ........................................................................ 46
  Medicaid/Healthy Kids ................................................................ 46
  Laboratory and Pathology Services ............................................. 46

Section 10 – Claims, Billing, Capitation & Encounters ....................... 48
  Coordination of Benefits ............................................................ 48
  Claim Status ............................................................................... 49
  How to Read Your Remittance Advice ........................................ 49
  Claim Detail ............................................................................... 49
  Editing Guidelines ...................................................................... 50
  High Dollar Claims (with expected payable amounts over $50,000) ................................................................. 50
  National Provider Identifier (NPI) ............................................... 51

Section 11 – EDI Claim & Encounter Submissions ............................... 52
  Monitoring Your EDI Reports .................................................... 54
  Common Rejection Reason ........................................................ 54
  EDI Assistance ........................................................................... 55
  Medical Necessity Reconsideration (Pre-Service) ......................... 55
  Important Information About Medicaid Member Appeal Rights ....... 56

Section 12 – Grievances and Appeals ................................................. 58

Section 13 - Provider Participating Status Dispute Resolution .............. 61
Section 14 – Overpayment Recovery

Section 15 – Credentialing

Practitioners Rights:
Board Certification:
Re-Credentialing:
Dual Specialties:
Ongoing Monitoring:

Section 16 – Pharmacy

The Formulary:
Prior Authorization:
Step Therapy:
Generic Substitution/Therapeutic Interchange:
Specialty Drugs:
Process For Requesting A Medication Coverage Exception:
Pharmacy Benefit Information:

Section 17 – General Information

Independent Contractor Relationship:
Administration

Section 1 – Overview

Introduction
Welcome to Coventry Health Care of Florida, Inc. an Aetna Company. Including, but not limited to Coventry Health Plan of Florida, Inc., Coventry Summit Health Plan and Coventry Health and Life Insurance Company (hereinafter collectively referred to as “The Plan”). The Plan has policies that cover enrollees in government programs such as Medicaid and Healthy Kids. We appreciate your participation in our network and welcome and encourage your comments and questions.

History
Coventry Health Care of Florida Inc., Coventry Health Plan of Florida Inc., Coventry Summit Health Plan and Coventry Health and Life Insurance Company are subsidiaries of Coventry Health Care, Inc. – acquired by Aetna Health Insurance May 2013 operating insurance companies, network rental and workers’ compensation services companies. The Plan offers a full range of risk and fee-based managed care products and services including HMO, PPO and POS, Medicare Advantage, Medicaid, Healthy Kids, Workers’ Compensation and network lease products to a broad cross-section of employer and government-funded groups, government agencies, individuals and other insurance carriers and administrators in all 50 states, as well as, the District of Columbia and Puerto Rico.

Purpose of this Manual
The purpose of this Provider Manual ("Manual") is to provide your office with business guidelines and requirements necessary to conduct business transactions with Coventry an Aetna company.

The manual contains meaningful information that makes it easier for you to work with us more effectively and efficiently. Topics range from how to get claims paid faster to learning how to reduce administrative burdens. We designed the office manual to give you more time to focus on what’s most important to you — improving the health and well-being of your patients.

Periodically, it will become necessary to update this Manual. Updated versions of this Manual are available at www.directProvider.com. Updates may also be delivered via fax, mailing or other electronic means for significant changes and/or updates. Please retain updates for future reference and guidance. Additional reference material can be located at chcmedicaid-florida.coventryhealthcare.com.

Protocols and Guidelines
Provider acknowledges and agrees that (i) all decisions rendered by The Plan its administration of the Agreement, including, but not limited to, all decisions with respect to the determination of whether or not a service is a covered service, are made solely to determine if payment of benefits under applicable member contract is appropriate; and (ii) any and all decisions relating to the necessity of the provision or non-provision of medical services or supplies shall be made solely by the member and Provider in accordance with the usual Provider patient relationship and Provider as applicable, shall have sole responsibility for the medical care and treatment of members under their care. Providers should encourage members under their care to review their member contract concerning benefits, procedures and exclusions or limitations prior to receiving treatment.
Key Contact Information

<table>
<thead>
<tr>
<th>Product</th>
<th>Customer Service</th>
<th>Medical Authorizations</th>
<th>RX Prior Authorizations</th>
<th>Claims Submission</th>
<th>Emdeon (WebMD/Envoy) Payor ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAID/HEALTHY KIDS</td>
<td>☎️ 800-441-5501</td>
<td>☎️ 800-447-3725</td>
<td>☎️ 866-847-8279</td>
<td>Coventry Health Care P.O. Box 7403 London, KY 40742</td>
<td>25133</td>
</tr>
</tbody>
</table>

Provider Tools

The Plan offers easy access to a variety of functions, web-based tools, and resources at [www.DirectProvider.com](http://www.DirectProvider.com). All participating Providers may use this resource to access business activity information such as:
- Claim inquiries
- Remittance advices
- Business forms
- Member benefit information
- Member health alerts
- Authorization requirements and information
- Member eligibility
- Provider Manual
- Other business information or documentation

The DirectProvider.com Customer Service Center is available to address questions regarding the web site and services. You may contact a representative at 1-866-629-3975. Hours of operation are Monday - Friday 8:00am to 6:00pm Eastern. Sign up is quick and easy at [www.DirectProvider.com](http://www.DirectProvider.com). Please have your FTIN, Provider CPD and IDX numbers available.

Translation Services

If a language barrier prevents you from communicating effectively with our members, we have translation services available to assist. Our language line provides interpreter services at no cost. Please contact our Customer Service Center at 866-847-8235. Inform the Customer Service Representative of your need of an interpreter and the language. The connection will be made for you.

For individuals with hearing impairment, we offer a 7-1-1 relay. For members who are hearing impaired, the health plan will utilize the 7-1-1 Telecommunications Relay Service (TRS). Members should call 7-1-1 and a representative will contact Customer Service on their behalf.

As a Provider of services, you should be aware of members who do not speak English or who have hearing impairments. Under Title VI of the Civil Rights Act and the Federal Rehabilitation Act, interpreter services must be available to ensure effective communication regarding treatment, medical history or health education. The Plan will arrange and pay for trained professionals when technical, medical or treatment information needs to be discussed with members.

Providers must offer the member access to interpreter services, even when the member brings a friend or family member to interpret.

In this event, the member must be offered interpreter services and be informed that the services are available at no charge; the friend or family member should not be used to interpret unless specifically requested by the member, after having been advised of the availability of free interpreter services.
**IVR (Integrated Voice Response System)**

Access to information such as eligibility, claim status and authorization are available by using our Integrated Voice Response system (IVR) by calling Customer Service and following the appropriate prompts.

**Forms & Reference Documents**

Required forms and reference documents can be downloaded and printed from the Resource Library under the downloadable forms section at: [www.DirectProvider.com](http://www.DirectProvider.com).

**Designated Liaison**

Each Provider’s office shall designate an office manager or administrator to be the primary contact person for Provider Relations department.

**Member Responsibility**

Providers acknowledge and agree that The Plan shall have no financial or other liability with respect to a member’s failure to pay Providers amounts due the Providers for co-payment, co-insurance, or deductible as required under the member’s contract or for non-covered services. Providers may not refuse to provide services to an eligible member solely because the member fails to pay the applicable co-payment at the time services are rendered.

**Direct Access and Cost-Sharing**

Providers shall, as mandated by State or Federal law, the applicable member contract and this Manual; (i) allow members direct access to certain specialist physicians; (ii) not inhibit members’ self-referral for certain services, including mammography screening and influenza vaccinations; and (iii) not impose cost-sharing on any member for influenza or pneumococcal vaccines. To the extent permitted by applicable law and benefit plan design (i.e. open access), members may self refer without a primary care physician ("PCP") referral for (a) mental and behavioral health services, (b) gynecologists and obstetricians; (c) chiropractors; (d) podiatrists for routine care; (e) dermatologists for five (5) visits per year; and (f) optometrists, if such services are covered for the member, in addition to any other services for which applicable law allows direct access.

**Marketing**

Any Provider marketing activities or materials for Coventry must be approved by Coventry in advance to ensure compliance with CMS and AHCA guidelines. This mandatory review will include letters announcing affiliation with Coventry, plan availability, events, health fairs, etc. Any gifts or promotional items must also follow guidelines promulgated by CMS or AHCA. Contact the Provider Relations representative for more information.

Providers may not make available, accept or distribute Coventry enrollment applications or offer inducements to enroll in a specific plan. Providers shall not offer anything of value to induce a prospective Member to select them as their Provider.

**Compliance and Ethics Program**

The Plan is dedicated to conducting our business in accordance with the highest standards of ethical conduct. We are committed to conducting business activities with uncompromising integrity and in full compliance with the Federal, State and local laws governing the health benefits industry. This commitment applies to relationships with shareholders, customers (enrollees, Federal Providers, State and local governments), vendors, competitors, auditors and all public and government bodies. Most importantly, it applies to Directors, Officers, employees and representatives. Each employee is responsible for upholding the highest level of ethical standards that exemplify professionalism and promote confidence in the organization.
Medicaid Program
Florida Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. The Florida Medicaid program is responsible for policies, procedures, and programs to promote access to quality acute and long-term medical, behavioral, therapeutic, and transportation services for Medicaid beneficiaries. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the families or individual’s income and assets.

Statewide Medicaid Managed Care Program
Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: one for medical assistance (MMA) and one for Long-Term Care (LTC).

Florida Agency for Health Care Administration’s Medicaid Coverage and Limitations Handbook
Providers may access the Florida Agency for Health Care Administration’s Medicaid Coverage and Limitations Handbook on the state’s website at www.fdhc.state.fl.us or handbooks may be obtained from AHCA. The handbooks provide more detail on the medical care, treatment and rights of Medicaid Members.

Coventry Health Care of Florida (CHCFL) and Providers shall comply with applicable AHCA handbooks and shall not be more restrictive than the limitations and exclusions in such handbooks.

Medicaid Fraud and Abuse Complaint Form
To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/inspectorGeneral/fraud_complaintform.aspx

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or health care provider, you may be eligible for a reward through the Attorney General’s Fraud Rewards Program (toll-free 1-866-866-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General’s Office about keeping your identity confidential and protected.
Provider Subcontractor Responsibilities
The Managed Care Plan shall be responsible for all work performed under this Contract, but may, with the prior written approval of the Agency, enter into subcontracts for the performance of work required under this Contract. All subcontracts must comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105 and 42 CFR 455.106.

Continuity of Care in Enrollment
Coventry shall be responsible for coordination of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers.

MMA Managed Care Plans shall provide continuation of MMA services until the enrollee’s PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee’s treatment plan, which shall be no more than sixty (60) calendar days after the effective date of enrollment.

Emergency Service Responsibilities
The Managed Care Plan shall provide pre-hospital and hospital-based trauma services and emergency services and care to enrollees. See ss. 395.1041, 395.4045 and 401.45, F.S.

a. When an enrollee presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. See ss. 409.9128, 409.901, F.S. and 641.513, F.S.

b. The physician, or the appropriate personnel, shall indicate on the enrollee’s chart the results of all screenings, examinations and evaluations.

c. The Managed Care Plan shall cover all screenings, evaluations and examinations that are reasonably calculated to assist the Provider in arriving at the determination as to whether the enrollee's condition is an emergency medical condition.

d. If the provider determines that an emergency medical condition does not exist, the Managed Care Plan is not required to cover services rendered subsequent to the provider's determination unless authorized by the Managed Care Plan.

e. 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 the Managed Care Plan, the hospital must make a reasonable attempt to notify:
   - The enrollee's PCP, if known, or
   - The Managed Care Plan, if the Managed Care Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

f. 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:

g. Notify the Managed Care Plan as soon as possible before discharging the enrollee from the emergency care area; or

h. Notify the Managed Care Plan within twenty-four (24) hours or on the next business day after the enrollee’s inpatient admission.

i. If the hospital is unable to notify the Managed Care Plan, the hospital must document its attempts to notify the Managed Care Plan, or the circumstances that precluded the hospital's attempts to notify the Managed Care Plan. The Managed Care Plan shall not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.
j. If the enrollee's PCP responds to the hospital's notification, and the hospital physician and the PCP discuss the appropriate care and treatment of the enrollee, the Managed Care Plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the enrollee within the scope of the physician's hospital staff privileges.

k. The Managed Care Plan shall advise all enrollees of the provisions governing emergency services and care. The Managed Care Plan shall not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, the Managed Care Plan shall not deny payment for treatment obtained when a representative of the Managed Care Plan instructs the enrollee to seek emergency services and care in accordance with s. 743.064, F.S.

**Requirements Regarding Background Screening**

Physicians and subcontractors shall be subject to background checks. Coventry shall consider the nature of the work Physician, subcontractors or agents performs in determining the level and scope of background checks for all treating providers not currently enrolled in Medicaid’s fee-for-service program, in accordance with the following:

- Coventry shall ensure providers not currently enrolled in Medicaid’s fee-for-service program submit fingerprints electronically following the process described on the Agency’s Background Screening website. Coventry shall verify Medicaid eligibility through the background screening system;
- Coventry shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;
- Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening; and
- Individuals listed in s. 409.907(8)(a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency’s background screening website.

**Cultural Competency**

**Introduction**

Coventry Health Care and its Florida affiliates recognize that a person’s cultural norms, values and beliefs shape how they approach and utilize health care services. Numerous cultural variables including, but not limited to, ethnicity, race, gender, age, socio-economic status, primary language, English proficiency, spirituality, religion and literacy level influence the way in which a person seeks and utilizes health services and the manner in which a person approaches and manages recovery.

The Cultural Competency Plan (CCP) has been developed to outline the methods used by Coventry Health Care of Florida, Inc., serving Medicaid enrollees located in Miami-Dade County, hereafter referred to as “the Health Plan”. The plan is developed to ensure that members receive care that is delivered in a culturally and linguistically sensitive manner. The CCP is comprehensive and incorporates all members, employees and providers. The Health Plan recognizes that respecting the diversity of our members has a significant and positive effect on outcomes of care and have adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards, as developed by the Department of Health and Human Services, Office of Minority Health, as guidelines for providing culturally and linguistically competent services. These 15 standards are organized by themes:

- Principle Standard (Standard 1)
The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that may experience unequal access to health services.

**Cultural Competence Definition:**
Cultural and linguistic competence is a set of coinciding behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. “Competence” implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities (Rural Assistance Center, 2008).

Stated more simply, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

Also, cultural competence can be defined as services that are sensitive and responsive to cultural differences whereby caregivers are aware of the impact of culture and possess the skills to help provide services that respond appropriately to a person’s unique cultural differences, including race and ethnicity, national origin, religion, age, gender, sexual orientation or physical disability.

**Goals of the Cultural Competency Plan**
The purpose of the Health Plans’ Cultural Competency Plan is to implement enterprise-wide methodologies and processes that measure and improve clinical care and services that are mindful of the language and cultural needs of the plans’ members.

The Health Plans have implemented procedures to assist their staff and Providers to develop awareness and appreciation of cultural customs, values and beliefs, and provide educational information and references to facilitate their incorporation into the assessment of, treatment of, and interaction with our members. The Health Plans encourage their staff to share and utilize their own cultural diversity to enhance the services provided to our members.

The Plan is committed to providing competent health care that is culturally and linguistically sensitive to members. The Health plans will achieve this by:

**Program Activities**

a. **Cultural Competency Workgroups**
Cultural Competency Workgroups are formed on an ad hoc basis to support the health plan in implementing portions of the CLAS project plan. An annual Cultural Competency Work plan/Project Plan (CCP) is developed to guide the activities of the health plan and the Company’s affected functional areas. The CCP Annual Evaluation is used to assess the progress of initiatives and make recommendations to the Quality Improvement Committee and executive leadership, when barriers are identified.
b. **Member Outreach**
   The Health Plan requests voluntary information on race and language from members and utilize this information to improve linguistic and cultural services. The Health Plan supports activities promoting Health Literacy and ensures member communications are in Plain Language.

c. **Member Satisfaction Assessment**
   Member satisfaction survey data is reviewed annually, paying special attention to those who identify themselves with limited English proficiency, in order to determine any identifiable clinical care and service gaps.

d. **Member and Provider Education**
   Cultural Competency articles are posted on the Provider, Member and Employee web portals or via the health plans approved communication venues. Provider and Employee Surveys are conducted in order to determine how best to assist the providers and employees in meeting the cultural needs of the population we serve. The Health Plan monitors complaints on a monthly basis from providers and subcontractors to ensure complaints regarding cultural and linguistically services are identified and resolved in a timely manner.

**Program Evaluation and Assessment**
Anually, the Health Plan conducts an evaluation of the Cultural Competency Plan to assess overall effectiveness and to determine future directions. The evaluation serves as the foundation for planning the upcoming year’s plan and activities relating to elevating cultural awareness. If you have any questions or would like to request a free copy of the Health Plan’s Cultural Competency Plan please call the Quality Department at 1-800-422-7335 extension 308-3576.

Providers and subcontractors are required to comply with the plan’s Cultural Competency Plan.

**Community outreach and marketing activities:**
Provider may not:

1. Offer marketing/appointment forms, make phone calls or direct, urge or attempt to persuade recipients to enroll in the Coventry Health Care of Florida based on financial or any other interests of the provider.
2. Mail marketing materials on behalf of the Coventry Health Care of Florida.
3. Offer anything of value to induce recipients/enrollees to select them as their provider.
4. Offer inducements to persuade recipients to enroll in the Coventry Health Care of Florida.
5. Conduct health screening as a marketing activity.
6. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
7. Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan. For a complete list of Community outreach and marketing activities, refer to [www.directprovider.com](http://www.directprovider.com)

**Abuse, Neglect and Exploitation**
1. The Managed Care Plan must ensure that all staff and providers are required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours of the incident. Reporting will include information including the enrollee’s identity, description of the incident and outcomes including current status of the enrollee. If the event involves a health and safety issue, the Managed Care Plan and case manager will arrange for the enrollee to move from his/her current location or change providers to accommodate a safe environment and provider of the enrollee’s choice.
2. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee’s case file, that is designated as confidential. Such file shall be made available to the Agency upon request.

3. Enrollee quality of care issues must be reported to and a resolution coordinated with the Managed Care Plan’s Quality Management Department.

**Florida SHOTS/Healthy Kids**

All PCPs that are participating with Florida Healthy Kids **must** enroll in Florida SHOTS, Florida’s statewide online immunization registry at the following link: [http://www.flshots.com/](http://www.flshots.com/)

Florida SHOTS is a statewide immunization registry developed by the Florida Department of Health (DOH). Florida SHOTS is designed to access and utilize a statewide immunization database. The registry is part of DOH's initiative to increase vaccination coverage for children across Florida.

Immunization registries are confidential, computerized information systems that track childhood immunization data. Children are entered into a registry either at birth, through a linkage with electronic birth records from Vital Statistics, or by health care providers. As childhood immunizations are given, the information is entered so that health care professionals know if immunizations are necessary or redundant.

Florida SHOTS receives vaccination information for children from across the state, including input from County Health Departments, private providers, the Bureau of Vital Statistics, and eventually from Women Infant and Children (WIC) clinics, and Medicaid. This immunization information will soon be available to schools, and childcare centers.

Immunization registries are essential for maintaining high immunization coverage levels. This is true particularly since disease levels are at record lows and outbreaks of preventable illnesses are becoming less common.

**Important Information for Medicaid Members**

All Medicaid PCP’s are required to post a copy of the Florida Patients Bill of Rights and Responsibilities in the open and conspicuous view of Medicaid Members. PCP’s are also required to post the Florida HMO Hotline number, (888) 419-3456, in the open and conspicuous view of all Medicaid Members.

If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount or for FFS Managed Care Plans, the Medicaid fee schedule amount, less any applicable copayments.

**Healthy Behaviors Program:**

The Plan will offer programs to our members who want to stop smoking, lose weight, or address any drug abuse problems. We will reward members who join and meet certain goals. These programs will be ready October 1, 2014. Additional information will be provided related to these programs at a later time.

**Listing of Medicaid Covered Services**

See table below for the Covered Services:

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CY 2012 – 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>Emergency service to hospital/$0 Copay</td>
</tr>
</tbody>
</table>
| Behavioral Health Services | PsychCare  
|---------------------------|-------------------------------------------------|
| (Inpatient, outpatient, physician services, community mental health, targeted case management for children & adults, intensive targeted case management for adults) | **Toll Free:** 800-221-5487  
| **Fax:** 800-370-1116 | Medical, social & educational resources  
| Services must be recommended by primary care physician or psychiatrist | Substance abuse  
| $0 Copay |  

| Child Health Check-Up Services | Up to age 20  
|-------------------------------|----------------|
| Health screening evaluation that shall consist of: comprehensive health and developmental history (including assessment of past medical history, developmental history and behavioral health status); comprehensive unclothed physical exam; developmental assessment; nutritional assessment; appropriate immunizations; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for enrollees beginning at age three or earlier as indicated); vision screening including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate. | MediKids - age 1-4  
| $0 Copay |  

| Chiropractic Services | $0 Copay  
<table>
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<tr>
<td>Up to 24 visits per year</td>
<td>See expanded benefits below</td>
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</table>

| Circumcision |  
|--------------|----------------|

| Dental Services – Children (under age 21) | MCNA Dental  
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<tr>
<td><strong>Toll Free:</strong> 800-464-6262</td>
<td></td>
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</table>

| Dental Services – Adult (age 21 & over) | Emergency & Denture Services: -800-494-6262  
|----------------------------------------|-------------------------------------------------|

| Dialysis Services | $0 Copay  
<table>
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</thead>
<tbody>
<tr>
<td>• In-center hemodialysis, in-center administration of injectable medication &amp; home peritoneal dialysis</td>
<td></td>
</tr>
<tr>
<td>• Routine lab tests, dialysis-related supplies &amp; ancillary/parenteral items</td>
<td></td>
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</tbody>
</table>

| Diabetic Supplies | $0 Copay  
|------------------|----------------|

| Durable Medical Equipment & Medical Supplies – (DME) | $0 Copay  
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<tbody>
<tr>
<td>• Medical or surgical items that are consumable, expendable, disposable or non-durable &amp; are appropriate for use in the patient’s home</td>
<td></td>
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<tr>
<td>• Must have prescription, plan if care or hospital discharge plan</td>
<td></td>
</tr>
<tr>
<td>• Documentation must be signed by/dated by physician with specific term, duration &amp; diagnosis</td>
<td></td>
</tr>
<tr>
<td>• Prior-authorized wheelchairs</td>
<td></td>
</tr>
<tr>
<td>• Some services for under 21 years of age</td>
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<table>
<thead>
<tr>
<th>Family Planning Services</th>
<th>$0 Copay</th>
</tr>
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<tbody>
<tr>
<td>(Member has access to par &amp; non-par Providers)</td>
<td></td>
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<tr>
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<td>• 60 visits per lifetime</td>
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<th>Immunizations (including those provided by county health departments)</th>
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<td>• Based on the recommended childhood immunization schedule for the U.S. and established by the Advisory Committee on Immunization Practices (ACIP)</td>
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<tr>
<td>• Up to age 20</td>
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<tr>
<th>Inpatient Hospital Services – Adult</th>
<th>$0 Copay</th>
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<td>• Coverage up to 45 days per fiscal year (7/1 to 6/30)</td>
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<th>Laboratory Services &amp; X-ray Services</th>
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<td>Covered outpatient hospital services included medical supplies, nursing care, therapeutic services and drugs. Some outpatient hospital services are limited to $1,500 for adults age 21 and older. There is no limitation for children 20 years of age or younger.</td>
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<th>Physician Services - Primary</th>
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<td>• Primary care Provider (PCP), psychiatrist, registered nurse practitioner, physicians assistant, ambulatory surgical center, rural health clinic, federally qualified health center, birthing</td>
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<tr>
<td>Service</td>
<td>Description</td>
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</tr>
<tr>
<td><strong>Physician Services - Specialist</strong> (Including, but not limited to)</td>
<td>Allergy, anesthesiology, cardiology, chiropractic services, dermatology, endocrinology, gastroenterology, general surgery, gynecology, infectious diseases, nephrology, neurology, obstetrics, oncology, ophthalmology, oral surgery, orthopedics, pathology, podiatry, psychiatry, pulmonology, radiology, therapy, urology</td>
</tr>
<tr>
<td><strong>Podiatry Services</strong></td>
<td>$0 Copay</td>
</tr>
<tr>
<td><strong>Prescription Drug Services</strong></td>
<td>Medicaid Formulary</td>
</tr>
<tr>
<td><strong>Therapy Services – Adults (age 21 &amp; over)</strong></td>
<td>Physical, Occupational therapy related to wheelchair evaluations and fittings. Speech therapy pertaining to the provision of augmentative and alternative communication systems.</td>
</tr>
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<td><strong>Therapy Services – Children (under age 21)</strong></td>
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</tr>
<tr>
<td><strong>Translation Services</strong></td>
<td>$0 Copay</td>
</tr>
<tr>
<td><strong>Transplant Services</strong></td>
<td>Evaluation, bone marrow; cornea, intestinal/multivisceral, kidney, pancreas, pre- and post transplant care including transplants not covered by Medicaid</td>
</tr>
<tr>
<td><strong>Transportation Services</strong></td>
<td>SFL Logistic Care : 866-726-1457</td>
</tr>
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<td><strong>Vision Services</strong></td>
<td>Contact lenses available only for unilateral or bilateral aphakia, Adult eyeglass frames and Eyeglasses (frames are limited to 1 pair every 2 years per recipient; lenses limited to 1 every 365 days based on medical necessity), All special eyeglasses and contact lenses must be prior authorized</td>
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*Some services may require a referral from your primary care physician*
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<tr>
<th>QUALITY BENEFIT ENHANCEMENTS</th>
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<tr>
<td>Smoking cessation</td>
<td>$0 Copay</td>
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<tr>
<td>Substance abuse</td>
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<tr>
<td>Domestic violence</td>
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<td>Pregnancy prevention</td>
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<tr>
<td>Children’s programs</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Disease management programs</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>diabetes, asthma, heart disease, hypertension, congestive heart</td>
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<tr>
<td>failure, chronic obstructive pulmonary disease, high risk</td>
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<tr>
<td>obesity, chronic kidney disease, dialysis, wound care,</td>
<td></td>
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<tr>
<td>pediatrics, neonatal intensive care, end of life</td>
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<tr>
<td>Physician</td>
<td>$0 Copay</td>
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<tr>
<td>Surgical</td>
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<th>EXPANDED BENEFITS/SERVICES</th>
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<tr>
<td>Circumcision</td>
<td>$0 Copay (Up to 12 weeks)</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Up to 24 visits per year</td>
<td></td>
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<tr>
<td>Circumcision</td>
<td>See expanded benefits below</td>
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<tr>
<td>Dental Services – Children (under age 21)</td>
<td>MCNA Dental</td>
</tr>
<tr>
<td></td>
<td>Toll Free: 800-494-6262</td>
</tr>
<tr>
<td>Dental Services – Adult (age 21 &amp; over)</td>
<td>Emergency &amp; Denture Services: 800-494-6262</td>
</tr>
<tr>
<td>Dialysis Services</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>In-center hemodialysis, in-center administration of injectable</td>
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<tr>
<td>medication &amp; home peritoneal dialysis</td>
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<tr>
<td>Routine lab tests, dialysis-related supplies &amp; ancillary/</td>
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<tr>
<td>parenteral items</td>
<td></td>
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<tr>
<td>Diabetic Supplies</td>
<td>$0 Copay</td>
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<tr>
<td><strong>Durable Medical Equipment &amp; Medical Supplies – (DME)</strong></td>
<td>$0 Copay</td>
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<td>• Medical or surgical items that are consumable, expendable, disposable or non-durable &amp; are appropriate for use in the patient’s home</td>
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<td>• Must have prescription, plan if care or hospital discharge plan</td>
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<tr>
<td>• Documentation must be signed by/dated by physician with specific term, duration &amp; diagnosis</td>
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</tr>
<tr>
<td>• Prior-authorized wheelchairs</td>
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<tr>
<td>• Some services for under 21 years of age</td>
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| **Family Planning Services**  
(Member has access to par & non-par Providers) | \$0 Copay |
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| **Home Health Services**  
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| **Immunizations** (including those provided by county health departments) | • Based on the recommended childhood immunization schedule for the U.S. and established by the Advisory Committee on Immunization Practices (ACIP)  
• Up to age 20                                                                                                                                                                                                                                                        | $0     |
| **Inpatient Hospital Services – Adult**      | Coverage up to 45 days per fiscal year (7/1 to 6/30)                                                                                                                                                                                                                                                                                         | $0     |
| **Laboratory Services & X-ray Services**     | Blood, urinalysis, freestanding facility, MRI, CAT scan                                                                                                                                                                                                                                                                                     | $0     |
| **Outpatient Hospital Services**             | Covered outpatient hospital services included medical supplies, nursing care, therapeutic services and drugs. Some outpatient hospital services are limited to $1,500 for adults age 21 and older. There is no limitation for children 20 years of age or younger.                                                                                                      | $0     |
| **Physician Services - Primary**             | Primary care Provider (PCP), psychiatrist, registered nurse practitioner, physicians assistant, ambulatory surgical center, rural health clinic, federally qualified health center, birthing center and county health department clinic                                                                                                                                 | $0     |
| **Physician Services - Specialist** (Including, but not limited to) | Allergy, anesthesiology, cardiology, chiropractic services, dermatology, endocrinology, gastroenterology, general surgery, gynecology, infectious diseases, nephrology, neurology, obstetrics, oncology, ophthalmology, oral surgery, orthopedics, pathology, podiatry, psychiatry, pulmonology, radiology, therapy, urology | Some services may require a referral from your primary care physician | $0     |
| **Podiatry Services**                        | Up to 4 visits per year without authorization                                                                                                                                                                                                                                                                                                | $0     |
| **Prescription Drug Services**               | Medicaid Formulary                                                                                                                                                                                                                                                                                                                          | $0     |
| **Therapy Services – Adults (age 21 & over)**| Physical, Occupational therapy related to wheelchair evaluations and fittings. Speech therapy pertaining to the provision of augmentative and alternative communication systems.                                                                                                                                                                            | $0     |
| **Therapy Services – Children (under age 21)**| Physical, Respiratory, Speech/Language, Occupational                                                                                                                                                                                                                                                                                           | $0     |
| **Translation Services**  
(Oral translations for non-English speakers) | $0 Copay |
| **Transplant Services**  
(Evaluation, bone marrow; cornea, intestinal/multivisceral, kidney, pancreas, pre- and post transplant care including transplants not covered by Medicaid) | $0 Copay  
Some limitations to services may apply |
| **Transportation Services**  
(Non-emergency) | SFL Logistic Care : 866-726-1457 |
| **Vision Services** | **Primary Plus aka CompBenefits**  
Toll Free 1-800-393-2873 / Option 3  
Fax 1-800-329-6030 |
| • Contact lenses available only for unilateral or bilateral aphakia  
• Adult eyeglass frames and  
• Eyeglasses (frames are limited to 1 pair every 2 years per recipient; lenses limited to 1 every 365 days based on medical necessity)  
• All special eyeglasses and contact lenses must be prior authorized | |

**QUALITY BENEFIT ENHANCEMENTS**

| Smoking cessation | $0 Copay |
| Substance abuse | $0 Copay |
| Domestic violence | $0 Copay |
| Pregnancy prevention | $0 Copay |
| Pre-natal/postpartum pregnancy | $0 Copay |
| Children’s programs | $0 Copay |
| Disease management programs  
diabetes, asthma, heart disease, hypertension, HIV/AIDS | $0 Copay |
| Physician | $0 Copay |
| Surgical | $0 Copay |

**EXPANDED BENEFITS/SERVICES**

| Circumcision | $0 Copay (Up to 12 weeks) |

**MEDIACID ENROLLEES RIGHTS AND RESPONSIBILITIES**

- Enrollees have the right to have your privacy protected
- Enrollees have the right to a response to questions and requests
- Enrollees have the right to know who is providing services to you
- Enrollees have the right to know the services that are available, including an interpreter if you don’t speak English
- Enrollees have the right to know the rules and regulations about your conduct
- Enrollees have the right to be given information about your health
- Enrollees have the right to get service from out-of-network providers
- Enrollees have the right to get family planning services from any participating Medicaid provider without prior authorization
- Enrollees have the right to be given information and counseling on the financial resources for your care
- Enrollees have the right to know if the provider or facility accepts the assignment rate
- Enrollees have the right to receive an estimate of charges for your care
Enrollees have the right to receive a bill and to have the charges explained
Enrollees have the right to be treated regardless of race, national origin, religion, handicap, or source of payment
Enrollees have the right to be treated in an emergency
Enrollees have the right to participate in experimental research
Enrollees have the right to file a grievance if you think your rights have been violated
Enrollees have the right to information about our doctors
Enrollees have the right to be treated with respect and with due consideration for your dignity and privacy
Enrollees have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
Enrollees have the right to participate in decisions regarding your health care, including the right to refuse treatment
Enrollees have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
Enrollees have the right to request and receive a copy of your medical records and request that they be amended or corrected
Enrollees have the right to be provided health care services in accordance with federal and state regulations
Enrollees are free to exercise your rights, and the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat you
Enrollees have the right to make a complaint or appeal about the health plan or the care it provides.
Enrollees have the right to make a recommendation regarding the health plan’s member rights and responsibilities

RESPONSIBILITIES

Enrollees should provide accurate and complete information about your health
Enrollees should report unexpected changes in your condition
Enrollees should report that you understand your care and what is expected of you
Enrollees should follow the treatment plan recommended
Enrollees should keep appointments
Enrollees should follow your doctor’s instructions
Enrollees should make sure your health care bills are paid
Enrollees should follow health care facility rules and regulations
Enrollees should understand your health problems and participate in starting equally agreed-upon treatment goals
Provider Participation

Section 3 – Provider Programs and Responsibilities

A Provider must complete an application, Provider Agreement and be fully credentialed as outlined in Section 14, in order to be approved for participation and treat any members. Upon execution of the agreement a copy will be returned to the Provider for his/ her records along with a welcome letter advising of product participation and effective dates.

Provider Selection Criteria

Our network is open for application by a particular Provider/Provider specialty type if at least one of the following criteria is met:

a. Access and availability standards are not being met in that area
b. There appears to be a need in the market place for a particular specialty due to referral patterns
c. Member, group or provider self nomination (Depending upon product and geography any provider requesting a direct contract, provider information will be shared with the specialty network for review and consideration.)

Changes to Provider Information or Status

Please notify The Plan in writing within sixty (60) days or in accordance with your agreement of any additions, deletions or changes to the topics listed below. Failure to notify The Plan timely could negatively impact claims processing.

- Tax identification number (submission of W-9 required). Changing a tax identification number will require a new agreement with the new tax identification number
- Office or billing address
- Telephone or fax number
- Specialty (may require additional credentialing)
- New physician additions to the practice (please allow time for credentialing)
- Licensure (DEA, state licensure or malpractice insurance)
- Group affiliation
- Hospital privileges

If you have any changes, written notification is required as far in advance as possible to The Plan’s Network Operations department. By providing the information prior to the change, the following is ensured:

- The practice address is properly listed in the Provider directory
- All claim payments are properly reported to the IRS
- There is no disruption in claims payments and claims are processed accordingly
• Members are notified in a timely manner if a change to their PCP becomes necessary or if they desire as a result of an address change or inability to continue participation.

**Member Identification**

All members receive an identification (ID) card shortly after enrollment. Members must present their ID card to their Provider at the time services are rendered. If the member is a recent enrollee who has not yet received a card, he/she must present a copy of the enrollment form. The ID card will list the member’s name, member number, primary care physician (PCP) (if applicable), group name and number, the benefit plan type, as well as copayments or coinsurance for office visits, prescriptions, outpatient and inpatient services. Benefits vary among different products. Therefore, it is important to reference the member ID card for the correct copayment or coinsurance amount. The ID card will also contain important customer service phone numbers for The Plan, the pharmacy vendor, and the mental health vendor.

**Acceptance of Members**

Provider shall accept as patients all Members that select or are assigned to a Provider unless otherwise agreed upon in writing. Written approval is required for a Provider’s panel to be frozen preventing or refusing new Members. Upon approval, Provider’s panel may remain open only to existing patients who are Members at the time the Provider’s panel is frozen (“Existing Members”). In such case, if a Member desires to select a Provider with a panel open only to existing Members, The Plan will contact the Provider to verify that the Member meets the criteria for an existing Member. If the Provider confirms that this is an existing Member, we will open the panel to allow that Member to select the Provider. Upon a Provider’s acceptance of a Member, Provider may terminate the Member from its panel or as its patient only upon satisfaction of applicable provisions of this Manual and applicable laws and regulations.

If a member is non-compliant or does not comply with the member rights and responsibilities as set forth herein, the Provider may notify the member of the situation in writing. However, the Provider may not terminate the member from their panel or services. Provider must request, in writing, that a member be removed from their panel; provided, however, that no such request can be based on the member’s medical condition, which request shall be determined by The Plan’s sole discretion. Such request must be sent to a Provider representative.

The Plan shall make reasonable efforts to confirm or deny eligibility using the most current information available; provided however, that Providers’ compliance with such verification procedures and/or confirmation of a member’s eligibility does not constitute a guarantee of such members eligibility or The Plan’s coverage of any services provided by Providers in reliance on such confirmation. Providers may verify eligibility by contacting a customer service representative or www.directProvider.com.

**Managing the Member’s Health Care**

Under certain member Contracts, a referral or pre-authorization define as authorization that must be obtained, or its designee, prior to the provision of certain covered services, as set forth in this manual and as required by the applicable coverage plan and the agreement. These Providers are listed on The Plan’s website. All pre authorizations using the (The CHCFL Prior Authorization Form) and referrals can be done electronically via www.directProvider.com. If a paper version is required, it can be downloaded and printed from the Resource Library in the Downloadable Forms section of The Plan’s Provider website at: www.directProvider.com.

No PCP referral is required for any care listed under the direct access provision of this manual. Except in the case of emergency services, urgently needed services, as otherwise permitted under this manual or applicable state or federal law, upon the prior written approval of a medical director or his/her designee, or as otherwise permitted under the applicable member contract, all referrals shall be made and pre-authorizations obtained by Providers in accordance with this manual, the agreement and the applicable member contract. Any laboratory services
provided to members in Providers’ offices shall not be reimbursable covered services, unless otherwise expressly provided in the agreement. PCP shall use his/her best efforts to provide members with any necessary referrals or obtain any required pre-authorization while the member is in PCP’s office.

Authorizing Treatment for Members
Authorization is not a guarantee of payment. All Providers must contact The Plan via www.directProvider.com, telephone or fax to obtain a pre-authorization prior to scheduling a member for any medical service subject to pre-authorization. The Plan may require the submission of clinical information to support a pre-authorization request. Hospitals shall notify The Plan of an admission occurring subsequent to the provision of emergency services.

Emergency services do not require pre-authorization.

IMPORTANT: The following services may not be covered under all member contracts even though such services are listed below. Members should refer to their summary of benefits or evidence/certificate of coverage for information regarding their covered services. This applies to all member contracts.

- Drug Order for Home Use
- Chemotherapy Drug Replacement
- Physician Office Medications

Timeliness of Authorizations
Providers are encouraged to submit their requests for authorization of services utilizing the Provider portal at www.directProvider.com. Best efforts shall be utilized to provide requested pre-authorizations immediately upon a Provider’s request; provided, however, that Providers agree to take a pending or tracking number with respect to a pre-authorization request in the event further information is required in making the pre-authorization coverage decision. Routine pre-authorization requests will be completed within seven to fourteen (7-14) calendar days of receipt of the request. All medical denial determinations will be made by a Florida licensed Medical Director. Denial letters will be sent to the member and Provider by fax or U.S. mail.

It is critical to allow enough time to process standard requests in a timely manner and only submit expedited requests when truly necessary. Expedited authorization is appropriate when a provider indicates, or the Managed Care Plan determines, that following the standard timeline could seriously jeopardize the enrollees life or health or ability to attain, maintain or regain maximum function.

Urgent pre-authorization requests will be processed within 48 to 72 hours of The Plan’s receipt of the request, unless additional information is required. The determination, approval or denial, will be verbally communicated or faxed to the requesting Provider and/or the member at the time the decision is rendered followed by written notice of a denial determination to the Provider and the member within (2) business days.

Authorization status can be obtained by using www.directProvider.com

Access to Care and Service Standards
Providers shall offer appointments and access to members within the following guidelines:

Primary Care Physicians

Aetna established standards for member access to primary care services are included in the participation criteria that are a part of each participating physician contract. Each primary care practitioner is required to have appointment availability within the following time frames:
• Routine care: within 7 days
• Routine preventive care: within 30 days
• Symptomatic care/non-urgent acute complaint (e.g., sore throat): within 3 days
• Urgent complaint: Same day or within 24 hours

In addition, all participating primary care physicians must have a reliable 24-hour-a-day, 7-day-a-week answering service or paging system. A recorded message or answering service that refers members to the emergency room is not acceptable.

Specialist physicians
For access standards specific to your state and specialty, refer to your contract.

PCPs are responsible for coordinating and managing the health care of their assigned members in accordance with the applicable member contract, this manual, and the agreement. PCPs provide primary care services to all their patients and coordinate all other covered services, including specialist services defined as those covered services generally provided by specialist physicians in their respective fields of training and experience.

Membership Assigned to PCPs
Members may choose a PCP from the Provider Directory. Every month, PCPs receive a membership listing of the members that have chosen them as their PCP. PCPs shall contact any new Medicaid members in their panel to ask if they need any assistance or to schedule an office visit for continued medical care.

Each PCP office shall designate an encounter/referral coordinator to ensure that encounters and referrals are completed and submitted to The Plan and/or the member. Encounters may be submitted electronically or on a CMS1500 form.

Hospitalist Program
Under The Plan’s Hospitalist Program (the “Program”), PCP acknowledges and agrees that hospitalist physicians provide primary care services which PCP is otherwise obligated to provide under the agreement on behalf of members assigned to PCP (“PCP Members”) who present as observation or as inpatients to a hospital, including, but not limited to (i) evaluation of PCP members presenting to the hospital’s emergency room; (ii) conducting daily hospital rounds of PCP members; (iii) coordinating care of PCP members and ensuring timely provision of covered diagnostic tests and procedures; (iv) communicating regularly with PCP, PCP members and the PCP members’ families, as appropriate; and (v) overseeing and coordinating discharge planning of PCP members with the PCP, The Plan and the hospital. PCPs who elect to participate in the program shall assign responsibility of PCP members to hospitalist physicians when PCP members present to the emergency department or are inpatients of a hospital.

In cases where a PCP elects not to participate in the program, the PCP shall continue to perform all other primary care services with respect to PCP members, including, but not limited to (i) resuming responsibility for all care, including follow-up care, of a PCP member immediately upon the PCP member’s discharge from the hospital; (ii) communicating all medical information/history to the hospitalist physician or other physician attending to a PCP member which is necessary to the PCP member’s care and treatment in the hospital; and (iii) performing any and all other requirements as requested by The Plan in connection with the PCP’s participation in the program.

Hospitals acknowledge and agree that if a PCP member presents to the emergency department, the hospital shall notify PCP member’s PCP and/or hospitalist physician participating in The Plan’s hospitalist program.
Section 4-Specialist Physicians

The member’s PCP is responsible for coordinating the provision of specialist services. The Specialist and the PCP work together to coordinate medical care for the member.

Referrals for Specialist Services
Except for (i) emergency services; (ii) urgently needed services; (iii) as otherwise permitted under this Manual, the applicable member contract or applicable state or federal laws; or (iv) upon the prior written approval of The Plan’s medical director or his/her designee, specialist shall not provide specialist services to members who’s member contract has a referral requirement unless the member furnishes specialist with a completed referral from the member’s PCP.

Follow-Up Care
Specialist shall coordinate the provision of specialist services with the member’s PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, shall not provide any follow-up or additional specialist services to members other than the covered services indicated on the applicable referral form provided to specialist by The Plan or the PCP. Within ten (10) business days of providing specialist services to a member, specialist shall furnish the member’s PCP with a written report regarding the member’s medical condition in such form and detail reasonably acceptable to the member’s PCP and The Plan. Specialist shall at all times promptly and openly communicate with the member’s PCP regarding the member’s medical condition, including, without limitation obtaining the appropriate pre-authorization should a Member require additional or follow-up covered services.

Except in the case of emergency services, Urgently Needed Services, as otherwise permitted under the applicable member contract, applicable law or upon the prior written approval of The Plan’s medical director or his/her designee, specialist shall refer members back to the member’s PCP in the event specialist determines the member requires the services of another specialist physician.

URGENTLY NEEDED SERVICES/URGENT CARE – Covered Services for conditions that (i) though not life-threatening, could result in serious injury or disability to the member unless medical attention is received or (ii) substantially restrict a member’s activity; and (iii) which are provided (a) when a member is temporarily absent from the service area or; (b) under unusual and extraordinary circumstances, when the member is in the service area but all participating Providers are temporarily unavailable or inaccessible when such covered services are medically necessary (as defined under Medicaid) and immediately required (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the covered services through a participating Provider. Examples include, without limitation, high fever, animal bites, fractures, severe pain, infectious illness, flu and respiratory ailments.

Prescriptions from OB/GYN:
A gynecologist or obstetrician may issue prescriptions for (i) covered services which do not otherwise require pre-authorization in accordance with this Manual; and (ii) covered services provided by gynecological oncologists, maternal and fetal medicine specialists, reproductive endocrinologists and uro-gynecologists. The gynecological oncologist, maternal and fetal medicine specialist, reproductive endocrinologist or uro-gynecologist must contact Coventry directly for pre-authorization prior to providing services to members.
Obstetricians
The obstetrical notification form should be completed during a members’ first prenatal visit. The form is located in the Resource Library under the Downloadable Forms section of the Plan’s website at www.directProvider.com.
Section 5-Hospitals

Hospital Emergency Services
In the case of an emergency medical condition, hospitals are not required to obtain pre-authorization from The Plan prior to providing emergency services to members; provided, however, that upon admitting a member into hospital, hospital shall immediately notify the hospitalist physician participating in The Plan’s hospitalist program or other designated Provider of such admission and obtain the required pre-authorization in accordance with this manual.

Except for emergency services, coverage of all services rendered to members by hospital are subject to The Plan’s sole determination of whether such service is a covered service under the applicable member contract. In the event it is determined that an emergency medical condition does not exist with respect to a member who presented to the hospital, hospital must comply with all pre-authorization requirements as set forth in this manual prior to providing any non-emergency services to a member.

Hospital’s failure to so obtain all required pre-authorizations for non-emergency services may, in The Plan’s sole discretion, result in The Plan’s denial of payment for such services as set forth in the agreement. Hospital shall comply with this manual and the agreement in providing non-emergency services to members. Hospital acknowledges and agrees that The Plan has the right to review the admission of any member for an emergency medical condition for appropriateness of continued stay in accordance with the manual.

Follow-Up Care
Hospital shall coordinate the provision of hospital services with the member’s PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, as otherwise permitted under the manual or applicable state or federal law or upon the prior written approval of The Plan’s medical director or his/her designees’, shall not provide any follow-up or additional hospital services to members other than the covered services in accordance with the pre-authorization for such services. Hospital shall at all times promptly and openly communicate with the member’s PCP regarding the member’s medical condition, including, without limitation obtaining the appropriate pre-authorization should a member require additional or follow-up covered services.
Section 6-Medical Records Guidelines

Medical Records
The Plan shall ensure maintenance of medical/case records for each enrollee in accordance with this section and with 42 CFR 431 and 42 CFR 456. Medical/case records shall include the quality, quantity, appropriateness and timeliness of services performed under the contract.

Providers shall prepare and maintain complete medical records for members under their care in a manner that complies with the following:

- Applicable federal and state laws
- Licensing, accreditation, and reimbursement rules and regulations applicable to Coventry, and
- Accepted medical practice

In accordance with federal and state law and the agreement, each Provider must protect the confidentiality of members’ patient records. To fulfill this obligation, Providers must designate a person to be in charge of the Provider’s medical records, and such person’s responsibilities include, but are not limited to, the following duties in accordance with federal and state law and the agreement:

- Maintaining the confidentiality, security, and physical safety of patient records
- Retrieving Member records in a timely manner upon the request of an authorized party, and
- Supervising the collection, processing, maintenance, storage, retrieval, and distribution of records

In accordance with the agreement and this manual, the medical records must be available for utilization review, risk management and peer review studies, customer service inquiries, grievance and appeals, and quality improvement initiatives.

All records should be kept confidential and maintained for seven (7) years. All Member information should be available to be transferred upon request by the member, or authorized representative, to any organization with which the member may subsequently enroll, or to a Provider to ensure continuity of care.

Providers must keep our members’ information confidential and stored securely. Providers must also ensure all staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that providers let us use your performance data for this purpose.

Medical Records Requests
Providers must respond and submit requested medical records to The Plan’s Grievance and Appeals and/or Quality Improvement departments promptly to enable the Plan to comply with Federal and Florida laws governing grievances and appeals and complaint investigation. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports.
Advance Directives
Providers shall document whether or not a member executed an advance directive in a prominent part of the member’s medical record. Providers shall certify if he/she/it cannot implement an advance directive on grounds of conscience as permitted by state law.

Medical Record Alteration or Falsification
Alteration or falsification of medical records is unethical conduct for any medical professional. Any incident relating to unethical behavior regarding medical record documentation is subject to the following process:

1. All incidents of possible medical record falsification are reported to The Plan’s Peer Review Committee and the Special Investigation Unit (SIU).
2. The Peer Review Committee reviews the records in question and allows the Provider to explain the circumstances.
3. The Peer Review Committee makes the final decision regarding the allegations of unethical conduct and takes appropriate actions.
4. Health professionals not subject to the peer review process (nurse, lab personnel, etc.) may be reported to the appropriate agency and/or governing body.

Transfer of Medical Records upon Termination of the Agreement
Upon the effective date of termination of the agreement (and the expiration of any period of any continuing care obligation), or such earlier date as a member may select or be assigned to another Provider regardless of whether the agreement then remains in effect, pursuant to a member’s or The Plan’s request, Provider shall copy all such member’s medical records in Provider’s possession and forward such records, at no cost to The Plan or to the member, to (i) such other Provider as designated by The Plan; (ii) the member; and (iii) The Plan, as requested by The Plan or the member.

Medical Records: Member Consent
Where required by law, Providers shall obtain specific written authorization from a member prior to releasing such member’s medical records. Providers acknowledge and agree that the consent by a member in the applicable member contract enrollment form and/or Providers’ standard consent form is hereby deemed satisfactory member consent for the release of members’ records, to the extent required by applicable law.

Member’s Rights to Access Medical Records
Providers shall ensure timely access by members to review, amend and obtain a copy of their medical records upon request, to the extent required by applicable law.
Section 7-Utilization Management Program & Clinical Practice Guidelines

Care/Case Management
As required by applicable law, The Plan has procedures to identify, assess and establish treatment plans for persons with complex or serious medical conditions. With respect to individuals with complex or serious medical conditions, Providers shall assist The Plan in (i) identifying such individuals; (ii) diagnosing, assessing and monitoring such individuals; and (iii) establishing and implementing treatment plans for such individuals that (a) are appropriate for their condition; (b) are time-specific; (c) are updated periodically; (d) ensure adequate coordination of care among Providers; and (e) include an adequate number of direct access visits to Providers consistent with the treatment plan. The Plan shall maintain written protocols for identifying, assessing and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care.

Medically Necessary or Medical Necessity
Services provided in accordance with 42 C.F.R. 438.210 (a)(4) and as defined in Section 59G-1.010(166), F.A.C., to include those medical or allied care, goods, or services furnished or ordered must:

a) Meet the following conditions:
   1. Be necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain;
   2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member’s needs;
   3. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
   4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
   5. Be furnished in a manner not primarily intended for the convenience of the member, the member’s caretaker, or Provider;
   6. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type
   7. “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.

b) The fact that Provider prescribed, recommended, or approved medical or allied goods, or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a Covered Service.
**Behavioral Health**

Coordination of care between the Primary Care Physician (PCP) and the Behavioral Health Practitioners (BHP) is critical to the well being of the patient.

The Plan uses a variety of mechanisms to monitor continuity and coordination of care between behavioral health and medical care. The Plan works collaboratively with our Behavioral Health vendors for the administration, management and monitoring the quality of behavioral health services for members.

Some of the indicators that The Plan may review on an annual basis are the exchange of information between behavioral healthcare and primary care physicians; the appropriate diagnosis, treatment and referral of behavioral health care disorders commonly seen in primary care; the appropriate use of psychopharmacological medications; management of treatment access and follow-up of members with co-existing medical and behavioral disorders; and primary or secondary preventive behavioral health care program implementation.

**Case Management**

Members may self-refer and Providers may refer members to The Plan’s case management programs. Providers may request assistance in the development of plans of treatment for members with complex or serious medical conditions. To make such a referral or to request assistance, please contact Case Management at (800) 447-3725. To refer a member to one of these programs, use the disease and case management referral form in the forms section of this manual. Fax the completed form to (860) 607-8056.

The case management nurse will work with the Provider, the member and the member’s family in an effort to help decrease the risk of complications, support coordination of care and provide education. These nurses will work with Providers to assess, plan and monitor options and services for members with chronic illness or injury.

Case management services are also offered to members upon discharge from the hospital, to help facilitate the receipt of post-discharge services administered by their Provider.

**Obstetrical Case Management Program**

An obstetrical nurse works with Obstetricians and Perinatologists to help coordinate services during pregnancy for members with high-risk conditions. The case manager also monitors the mother and newborn progress through the sixth week postpartum follow-up visit. To make a referral for the OB Case Management program, fax the case management referral form to (877) 479-8546.

**Pediatric Case Management Program**

Pediatric members with catastrophic or chronic diseases are supported by a pediatric nurse who works with the member’s Providers and family, while the child is in the hospital or at home. The nurse works to identify participating Providers, and resources in the area to meet the child’s needs as defined by the Providers. To refer a member for the Pediatric Case Management Program, fax the referral form to (860) 607-8056.

**Transplant Case Management Program**

Transplant candidate members should be referred to the transplant coordinator. To refer a member to the Transplant Coordinator, fax the referral form to (860) 607-8056.
Disease Management Programs

Disease Management programs are population-based programs designed to improve the health status of members with chronic diseases by actively intervening to assist members and practitioners manage the disease. The Plan provides bi-lingual staff to support Spanish-speaking members. The Plan maintains five disease programs: Congestive Heart Failure, Diabetes, Asthma, Hypertension and Renal Disease Management. The programs are based on scientific literature and industry disease management standards. Separate program descriptions are maintained for each program.

Members are identified using a clinical rules program which pulls claims data regarding diagnosis, medication, laboratory testing and procedures. Based on analysis of the data extracted, those members meeting selected disease state criteria will be enrolled in one of the identified disease management programs. Members may also be identified through any of the following processes:

- Member completes a health risk assessment form after enrollment;
- Member admitted to acute care facility and reviewed by the concurrent review nurse. Nurse makes referral to disease management program, as appropriate;
- PCP may contact The Plan to refer a member to a program by faxing a disease management referral form to (860) 607-8056. See the forms section of this manual for a sample form;
- Member self-refers through customer service.

Once the member is identified as eligible to participate in the program, he or she is stratified by disease severity and placed in one of the following tiers:

**Tier I - Low:** The member is notified of the appropriate disease management program and provided educational materials through mail. Members are encouraged to contact their disease management nurse if they need assistance, guidance or have any questions regarding their disease. Once a member is identified as having a disease state, and literature has been mailed, they are automatically enrolled in the disease management program. Members who wish to disenroll in the program will be directed to contact their disease management nurse or call the Customer Service department.

**Tier II - Moderate:** All of the above interventions as well as a Disease Management nurse will contact the member to perform an assessment for their specific condition. Nurses also provide focused education on disease, diet, exercise and medication and discuss the importance of self-management. The nurse will communicate with the member and their attending physician to coordinate a treatment plan.

**Tier III - High:** Members meeting the highest criteria with CHF, diabetes or asthma are enrolled in a Tier III program. In addition to the components featured in Tier I and Tier II, these members also receive an in-home monitoring device that records, on a daily basis, clinical data related to their condition. This information is relayed electronically to The Plan which is reviewed by the Disease Management nurse. If the nurse receives data that indicates an exacerbation or complication of the disease, the member and physician will be called to facilitate an intervention so the appropriate medical treatment can be provided to the member in a timely manner.

The member may call a case manager at any time during normal business hours, Monday through Friday, between 8:30 a.m. and 5:30 p.m. Once the ember is stable, communication will be less frequent; however, the member may contact the case manager at any time. To speak with a disease case manager call (800) 447-3725. You will be connected to the appropriate disease case manager for the following conditions:
Chronic Care Improvement Program (CCIP)

To support the PCP in managing the care of members with CHF, diabetes, and chronic renal disease, The Plan offers CCIP. Potential members will be identified by The Plan. To be eligible, the member must have been enrolled with The Plan for at least six (6) continuous months.

Once the members are identified, The Plan will contact the member’s PCP to participate in the program. The Disease Case Manager will contact the member to perform a comprehensive assessment. If indicated, The plan’s licensed Social Worker will conduct a home visit. The Disease Case Manager and the Social Worker will contact the PCP to develop a care plan. The member and member’s family or caregiver will be contacted and provided education on disease state, diet, medication and care plan.

Clinical Practice Guidelines

The Plan’s employees make clinical decisions regarding members’ health based on the most appropriate care and service available. The Plan makes these decisions based on appropriate clinical criteria. The clinical guidelines and criteria used by the Health Services Departments are available to practitioners on the health plan website or via access to www.DirectProvider.com.

A member’s participation in The Plan’s Disease Management programs is not a substitute for a physician's medical advice or treatment. The Plan does not intend to exercise any control or direction over a physician's medical judgment or clinical decisions, or to interfere with the physician/patient relationship between Providers and their patients. The following clinical practice guidelines are intended to be educational and informational in nature and are not meant to substitute for a Provider’s medical judgment or advice.

Diabetes Clinical Practice Guidelines

Purpose

As part of our goal of providing quality care and improved health outcomes, as well as improving Provider awareness, The Plan supports the use of evidence-based medicine to reduce unnecessary variations in care. For diabetes management, The Plan has adopted the current recommendations from the American Diabetes Association, a recognized, national, expert source on diabetes management. A summary of the standards may be accessed at: http://care.diabetesjournals.org/content/33/Supplement_1/S4.full.pdf

This is intended solely as a guide and information source. The Plan recognizes that any management plan should be individualized and developed in coordination with the physician, health care team, patient and family, as deemed necessary.

Diabetes is a chronic illness that requires continuing medical care and patient self-management education to prevent acute complications and to reduce the risk of long-term complications. Diabetes care is complex and requires that many issues, beyond glycemic control, be addressed. A large body of evidence exists that supports a range of interventions to improve diabetes outcomes.

1 “Please note that not all health insurance and group health plans cover all recommended services. Please check the member’s benefit documents to determine whether their health insurance or group health plan covers these services”
Guidelines Components to be Monitored

- Hemoglobin A1C testing
- Percentage of members with Hemoglobin A1c greater than 9% (poor control)
- Percentage of members with Hemoglobin A1c less than 8% (good control)
- LDL screening rates
- LDL-C control (Less than 100 mg/dL)
- Diabetic nephropathy testing
- Diabetes – eye examinations

Interventions

- By evaluating claims data, The Plan will collect data to verify Provider and member compliance with the guideline recommendations for the above components
- Educational information and individual Provider feedback will be provided where compliance rates do not meet benchmark goals
- All members with diabetes will be assessed for participation in the diabetes disease management program, to facilitate achievement of clinical outcome goals

Clinical Outcome Goals

Hemoglobin A1C level < 8.0%
Lipid control: LDL-C < 100 mg./dL
Annual eye examination
Urine albumin and serum creatinine testing annually

Asthma Clinical Practice Guidelines

Purpose
In its efforts to improve Provider and member awareness of nationally established practice guidelines for common disease states, The Plan supports the clinical practice guideline for asthma outlined in 2007 by the National Asthma Education and Prevention Program of the National Institutes of Health. Members and Providers may access the asthma clinical practice guideline in its entirety at: [http://www.nhbli.nih.gov/guidelines/asthma/index.htm](http://www.nhbli.nih.gov/guidelines/asthma/index.htm)

Physicians are encouraged to familiarize themselves with the guideline and to incorporate the guideline into their daily patient management. As with all guidelines, it is intended to offer evidence-based guidance for treating this disease, with the understanding that a physician’s treatment plan for any particular patient will be individualized. It offers a consensus opinion on the standard of care, keeping in mind that variations from it are expected when a patient’s particular clinical circumstances so require.

The Plan intends to select several standards from within the guideline each year for particular focus and will monitor rates of adherence to those standards (referenced below as a “monitored standard”). Again, it is understood that deviations from any particular standard may occur based on physician judgment. Nevertheless, the overall rates of compliance will be instructive, and it is The Plan’s goal to improve overall compliance on those standards for appropriate patients.
Definitions
Asthma severity is classified in persons 5 years of age and older by assessing the level of impairment. The severity level is based on the child’s/caregiver’s recall of the 2-4 weeks just prior to the assessment.

- Severe persistent - continual daytime symptoms, frequent nighttime symptoms, and extreme limitation of normal activity
- Moderate persistent – daily daytime symptoms or symptoms more than one night per week, and some limitation of normal activity
- Mild persistent – daytime symptoms more than twice per week but less than once a day or symptoms more than two nights per month, and minor limitation of normal activity
- Intermittent – daytime symptoms less than or equal to two days per week and less than or equal to two nights per month, and no limitation of normal activity

Guideline Components To Be Monitored – The Plan will monitor:
- The use of inhaled corticosteroids in asthmatic members age five and older with two or more emergency department visits and/or one inpatient admission for asthma in the past year
- The use of long-acting bronchodilators in asthmatic members age five and older with two or more emergency department visits and/or one inpatient admission for asthma in the past year
- The number of asthma-related emergency department visits annually in members age 5 and older
- The number of asthma-related inpatient admissions annually in members age five and older

Data Tracking – The Plan will track all pharmacy claims for inhaled corticosteroids and inhaled long-acting beta agonists and record the following specifics for each claim:
- Member name
- Provider name/ whether Provider is PCP or specialist
- Panel size of Provider

The Plan will track claims for the two pharmaceutical agents above and compare claims per 1000 members against established benchmarks for utilization of these two agents (allowing for mail order claims for up to 90 days of medication per claim).

Clinical Outcome Goals
- Increased use of inhaled corticosteroids in asthmatic members
- Increased use of long-acting bronchodilators in asthmatic members
- Reduction in number of asthma-related emergency department claims for members
- Reduction in number of asthma-related inpatient claims for members

Congestive Heart Failure

Purpose
Congestive Heart Failure (CHF) is a prevalent disease in Medicare members and that prevalence is reflected in The Plan membership.

In an effort to improve Provider and member awareness of nationally established practice guidelines for common disease states, The Plan encourages Providers and members to use clinical practice guidelines as reference tools for giving and receiving care. Providers are encouraged to familiarize themselves with applicable guidelines and to refer to them in their daily patient management.
The Plan recognizes the guideline for CHF management developed by the American College of Cardiology (ACC). A complete copy of the guideline, may be found at: http://content.onlinejacc.org/cgi/reprint/53/15/e1.pdf

This is intended solely as a guide and information source. The Plan recognizes that any management plan should be individualized, and developed in coordination with the physician, healthcare team, patient, and family, as deemed necessary.

**Guideline Components To Be Monitored**
- Prescription fill rates of ACEI/ARB
- Prescription fill rates of beta blockers
- Annual lipid testing rates

**Interventions**
- By evaluating claims data, The Plan will collect data to verify member and Provider compliance with ACEI/ARB, beta blocker and lipid testing, as recommended by the guideline
- Educational information and individual Provider feedback will be provided where compliance rates do not meet benchmark goals
- All members with diabetes will be assessed for participation in the CHF disease management program to facilitate achievement of clinical outcome goals

**Clinical Outcome Goals**
- Increased use of ACEI/ARB increased use beta blockers
- Appropriate lipid testing rates

**Skilled Nursing Admissions**
Skilled nursing facility admissions require pre-authorization. The concurrent review coordinator, as part of the discharge planning process, usually performs pre-authorization of SNF admissions. Following the admission, the concurrent review coordinator will review the stay via the telephone or onsite with the facility case manager (or designated facility review staff).

**Rehabilitation Admissions**
Admissions to rehabilitation facilities require pre-authorization, which is often performed by the concurrent review coordinator as a part of discharge planning. Concurrent review may be performed telephonically or onsite.

**Discharge Planning**
The concurrent review coordinator will begin the discharge planning process at the time of an inpatient, skilled nursing, or rehabilitative facility admission. The concurrent review coordinator will collaborate with the hospital discharge planner and the member’s physician to ensure that the member receives all medically necessary covered services available within the member’s contract at the time of discharge.

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2 “Please note that not all health insurance and group health plans cover all recommended services. Please check the member’s benefit documents to determine whether their health insurance or group health plan covers these services”
Second Opinions
Florida Statute 641.51 requires that The Plan provide members with access to a second medical opinion in any instance in which the member disputes The Plan’s or the Provider’s opinion of the reasonableness or necessity of surgical procedures or is subject to a serious illness or injury. If requested, the member may select a Provider or a non-participating Provider in the geographical service area of The Plan.

If the member selects a participating Provider, PCPs may issue a referral for the second opinion. If the member selects a non-participating Provider, the PCP must request a pre-authorization from The Plan.

New Medical Technologies
The Plan evaluates benefit coverage for new medical technologies or new applications of existing technologies on an ongoing basis. These technologies may include medical procedures, drugs and devices. The following factors are considered when evaluating the proposed technology:

- Input from appropriate regulatory bodies.
- Scientific evidence that supports the technology’s positive effect on health outcomes.
- The technology’s effect on net health outcomes as it compares to current technology.

The evaluation process includes a review of the most current information obtained from a variety of authoritative sources including medical and scientific journals, medical databases and publications from specialty medical societies and the government.
Section 8 – Quality Improvement

Quality Improvement

The Quality Improvement Department identifies high-volume, high-risk and problem prone areas of care and service affecting members. To the extent required by applicable law and regulations and requirements of applicable accreditation organizations, the Quality Improvement department also:

Undertakes quality improvement initiatives:

- Audits medical records and provides feedback on the results of those audits to Providers
- Conducts retrospective review and investigation of complaints regarding quality of care
- Shares findings with other committees, such as the Credentialing Committee, Peer Review Committee and Quality Improvement Committee

HEDIS™

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that the public has the information needed to reliably compare performance of managed health care plans. Some frequently asked questions regarding HEDIS data collection are addressed below:

Why do health plans collect HEDIS data?
The collection and reporting of HEDIS data are required by the Centers for Medicare and Medicaid Services (CMS) for Medicare Members. Accrediting bodies such as the National Committee for Quality Assurance (NCQA) and many states also require that health plans report HEDIS data. The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

How are HEDIS measures generated?
HEDIS measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review on a sample of members along with claims and encounter data)
- Survey

Why does The Plan need to review medical records when it has claims data for each encounter?
Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of tests that may not be available in claims/encounter data. Typically, an employee will call the physician’s office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the Provider to fax or mail the specific information.

How accurate is the HEDIS data reported by The Plans?
HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so The Plan may ask for copies of records for audit purposes. We also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.
Is patient consent required to share HEDIS related data with The Plan?
The HIPAA privacy rule permits a Provider to disclose protected health information to a health plan for the quality – related health care operations of the health plan, including HEDIS, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506(c) (4).

May the Provider bill The Plan for providing copies of records for HEDIS?
According to the terms of a Provider’s agreement, Providers may not bill either The Plan or the member for copies of medical records related to HEDIS.

How can Providers reduce the burden of the HEDIS data collection process?
We recognize that it is in the best interest of both the Provider and The Plan to collect HEDIS data in the most efficient manner possible. Options for reducing this burden include providing The Plan remote access to Provider electronic medical records (EMR) and setting up electronic data exchange from the Provider EMR to The Plan. Please contact your Provider relations representative or The Plan’s Quality Improvement Department for more information.

How can Providers obtain the results of medical record reviews?
The quality improvement department can share the results of the medical record reviews performed at your office and show you how your results compare to that of The Plan overall. Please contact your Provider Relations Representative or the quality improvement department for more information.

Medical Quality Performance Measure
The technical specifications, measures, and score criteria are subject to change at any time based upon changes issued by HEDIS or NCQA. The Plan shall use best efforts to notify Physicians of such changes prior to their effective date; however such changes shall not be subject to the formal notice and amendment provisions of the Agreement. At all times, physician shall be evaluated based upon the then-current technical specifications, measures, and score criteria in effect.

1. Evidence Based Medicine Guidelines (EBM)

   **Goal:** Improve compliance to the following evidence based guidelines.

   **Bone & Joint Conditions**

   - Osteoporosis management in women who have a fracture. -% of women with t fracture who have either a DEXA of osteoporosis drug in subsequent 6 months (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

   **Comprehensive Adult Diabetes Care**

   - HbAlc testing - The percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had Hemoglobin Alc (HbAlc) testing (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.
• Eye exam (retinal) – The percentage of members 18 to 75 years of age with diabetes (type 1 and 2) who had an eye screening for diabetic retinal disease in the measurement year or negative retinal exam in the year prior to the measurement year. (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

• LDL-C screening – The percentage of members 18 to 75 years of age with diabetes (type 1 and 2) who had an LDL-C test performed during the measurement year as identified by claim/encounter or automated laboratory data. (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

**Annual Monitoring for Patients on Persistent Medication** (on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB))

• Annual monitoring for members on ACE/ARB -The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

**Antidepressant Medication Management**

• The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported:

  2. **Effective Acute Phase Treatment.** The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

  3. **Effective Continuation Phase Treatment.** The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months). (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

**Use of Spirometry Testing in the Assessment and Diagnosis of COPD** (Measure starts in Year 2)

• COPD Spirometry - The percentage of members 40 years of age and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. - (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

**Breast Cancer Screening**

• The percentage of women 50 to 74 years of age with one or more mammograms during the measurement year or the year prior to the measurement year. (NCQA/HEDIS) – Current Year HEDIS Technical Specifications.

**Colorectal Cancer Screening**

• The percentage of members 50 to 75 years of age who had an appropriate screening for colon cancer. - (NCQA/HEDIS) - Current Year HEDIS Technical Specifications

**Glaucoma Screening in Older Adults**

• The percentage of members 67 years and older, without a prior diagnosis of glaucoma or glaucoma suspect, who had one or more eye exams for glaucoma by an eye care professional. - (NCQA/HEDIS) - Current Year HEDIS Technical Specifications
Cholesterol Screening for Patients with Heart Disease
- The percentage of members with heart disease who had a test for LDL cholesterol in the past year. - (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

Heart Failure – ACE and Acceptable Alternatives
- The percentage of members 18 years and older identified with congestive heart failure (CHF) and filled a prescription for an ACE-inhibitor, Angiotensin II Receptor Antagonist, Hydralazine or Nitrate medication during the last 120 days of the period through day 90 days after the end of the report period. - (Ingenix custom measure)

Coronary Artery Disease (CAD) – ACE and ARB
- The percentage of members 18 years and older identified with coronary artery disease (CAD) and filled a prescription for an ACE-inhibitor or Angiotensin II Receptor Antagonist, medication during the last 120 days of the period through day 90 days after the end of the report period- (Ingenix custom measure)

2. Rx Compliance

Goal: Improve pharmacy compliance and performance for the following conditions and measures.

Acute MI
- Beta blocker after heart attack -% of member’s age 35 or greater diagnosed with MI with a prescription for a beta blocker during the measurement year (NCQA/HEDIS) - Current Year HEDIS Technical Specifications.

Rate of Generic prescription
- Ratio of generics to brand
- Formulary compliance rate

3. Avoidable ER

Goal: Decrease avoidable emergency room visits for select diagnosis codes. This metric will be measured based on a per 1000 utilization rate based on the total Members.

Risk Management Program
Providers shall participate in and cooperate with The Plan risk management program. The Managed Care Plan shall require participating and direct service provider to report adverse incidents to the Managed Care Plans within twenty-four (24) hours of the incident. The Managed Care Plan must ensure that all participating and direct service providers are required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours of the incident. Reporting will include information including the enrollee’s identity, description of the incident and outcomes including current status of the enrollee. The Plan developed and implemented an incident reporting system to minimize injury/incidents to members, employees and visitors. The risk management program and incident reporting policy and procedures comply with §59A-12.012, Florida Administrative Code (Internal Risk Management Program for HMOs) and §641.55, Florida Statute (Internal risk management program for HMOs).
ADVERSE or UNTOWARD INCIDENT – an event, as defined in Chapter 395.0197(5) of the Florida statutes, over which Provider could exercise control which is more probably associated, in whole or in part, with the medical intervention rather than the medical condition for which such medical intervention occurred and which results in one of the following:

a. Death;
b. Brain or spinal damage;
c. Permanent disfigurement;
d. Fracture or dislocation of bones or joints;
e. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;
f. Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the member has not given his/her informed consent; or 
g. Any condition that required the transfer of the member, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the member’s condition prior to the adverse incident, including:
   1. The performance of a surgical procedure on the wrong patient, a wrong surgical procedure or wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the member’s diagnosis or medical condition;
   2. Required surgical repair of damage resulting to a member from a planned surgical procedure where the damage was not a recognized specific risk, as disclosed to the Member and documented through the informed-consent process;
   3. A procedure to remove unplanned foreign objects remaining from a surgical procedure; or
   4. Any complaint or allegation of sexual misconduct and abuse, or contact by Provider employee or agent of Provider.

If an adverse or untoward incident occurs to a member, Provider shall report the adverse or untoward incident (as defined under Florida law) to The Plan’s risk manager within twenty-four (24) hours after its occurrence. Provider shall (i) participate in and cooperate with The Plan’s risk management program; (ii) provide such medical and other records without charge within ten (10) days of receipt of written notice; (iii) share such investigation reports and other information as may be required or requested by The Plan’s risk manager to determine if an adverse or untoward incident is reportable as a “Code 15” to AHCA; and (iv) in all other respects comply with and abide by this Manual. A Provider’s failure to comply with these requirements may be deemed a material breach of the agreement, at The Plan’s sole discretion.

When an incident occurs:

- Complete the incident report (located in the forms section) form immediately when becoming aware of an adverse or untoward incident
- Fill each blank on the form, using N/A when not applicable to the particular occurrence
- Write legibly or type the information on the form
- Describe the incident carefully. Be brief, but include important information, including who, what, where, when and how
- Indicate the body part injured, the location and extent of injury and document fully, including lack of injury
- Report any pertinent action taken in response to the occurrence
- Obtain the name and location information for any witnesses, including employees
- Sign and date the report. Include title/designation and contact phone number
- Fax to risk manager at: (877) 479-8564
For assistance in completing the incident report form, contact a Risk Manager at (954) 858-3246.

Incident reports are part of risk management files only and copies of incident reports must be maintained separately from member’s medical records.

All incident reports will be reviewed and date stamped upon receipt. Appropriate action will be initiated when indicated. Incident reports will not be used to penalize Providers; however, failure to report an adverse or untoward incident may result in further action.
Section 9 – Fee Schedule Maintenance & Reimbursement Determinations

The schedule of allowances represents the maximum reimbursement amount for each covered service that corresponds to any given medical service code. The basis of determining valid medical service codes are from Current Procedural Terminology (CPT), HCFA Common Procedural Coding System (HCPCS), or National Drug Codes (NDC). For covered services represented by a single code, the maximum reimbursement amount is the allowance amount determined by The Plan or the Provider’s usual charge for the service, whichever is less. In many cases, The Plan allowances are based upon measures of relative value such as Average Wholesale Price (AWP), the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) units and Medicare laboratory and Durable Medical Equipment (DME) rates. Your Contract will outline the specific fee schedule methodology used to determine your rates.

Medicaid/Healthy Kids
The Plan updates all Medicaid based fee schedules as published by Medicaid and in accordance with Medicaid effective dates assigned to codes and reimbursement.

Upon publication of codes previously not valued by Medicaid, The Plan will update Medicaid based schedules accordingly. The Plan will request code specific discrepancy reports be pulled; claims will be reviewed and over and underpayments will be handled accordingly with Providers.

The Plan will reprocess any Provider claims affected by new codes upon Provider’s written request.

Laboratory and Pathology Services
Laboratory and pathology services must be performed by a participating laboratory. The Plan maintains a contract with LabCorp to provide outpatient lab services for members. LabCorp provides all necessary supplies; request forms; specimen pick-up; accurate and prompt test results.

Laboratory and pathology services provided by an outside or reference lab that is not the applicable contracted laboratory Provider (LabCorp) will not be reimbursed to the Provider of service by The Plan. Laboratory and pathology services include but are not limited to clinical labs, nonclinical labs, pathology, and dermatology. If services are performed in office, the Provider may not bill the member/patient or for the laboratory/pathology services. LabCorp must be used for all Medicaid and Healthy Kids members.
Although maintains a contract with LabCorp to provide lab and path services, we recognize the need for urgent lab work to make a diagnosis, or to treat the patient while in the Provider’s office. When this situation occurs, some lab procedures listed below can be billed to and the Provider will be reimbursed according to the schedule below:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Code Description</th>
<th>Allowable Rate</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>36410</td>
<td>Non-routine Blood draw &gt; 3 yrs</td>
<td>$ 3.00</td>
<td>ALL</td>
</tr>
<tr>
<td>36415</td>
<td>Routine venipuncture</td>
<td>$ 3.00</td>
<td>ALL</td>
</tr>
<tr>
<td>81000</td>
<td>Urinalysis manual</td>
<td>$ 2.00</td>
<td>ALL</td>
</tr>
<tr>
<td>81001</td>
<td>Urinalysis automated</td>
<td>$ 2.00</td>
<td>ALL</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis non automated w/o microscopy</td>
<td>$ 3.00</td>
<td>ALL</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis automated w/o microscopy</td>
<td>$ 3.00</td>
<td>ALL</td>
</tr>
<tr>
<td>81005</td>
<td>Urinalysis</td>
<td>$ 3.00</td>
<td>Urology Providers Only</td>
</tr>
<tr>
<td>82247</td>
<td>Bilirubin</td>
<td>$ 10.00</td>
<td>ALL</td>
</tr>
<tr>
<td>82947</td>
<td>Glucose; quantitative</td>
<td>$ 3.00</td>
<td>ALL</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose blood; reagent strip</td>
<td>$ 3.00</td>
<td>ALL</td>
</tr>
<tr>
<td>84520</td>
<td>BUN - Assay of urea nitrogen (HEDIS Code)</td>
<td>$ 8.00</td>
<td>ALL</td>
</tr>
<tr>
<td>85002</td>
<td>Bleeding time test</td>
<td>$ 4.00</td>
<td>Hematology/Oncology Providers Only</td>
</tr>
<tr>
<td>85007</td>
<td>B1 smear w/diff w/bc count</td>
<td>$ 4.00</td>
<td>Hematology/Oncology Providers Only</td>
</tr>
<tr>
<td>85008</td>
<td>B1 smear w/o diff w/bc count</td>
<td>$ 4.00</td>
<td>ALL</td>
</tr>
<tr>
<td>85013</td>
<td>Blood count; spun micro hematocrit</td>
<td>$ 2.00</td>
<td>ALL</td>
</tr>
<tr>
<td>85018</td>
<td>Hemoglobin</td>
<td>$ 2.00</td>
<td>ALL</td>
</tr>
<tr>
<td>85025</td>
<td>CBC</td>
<td>$ 6.00</td>
<td>ALL</td>
</tr>
<tr>
<td>85027</td>
<td>Hemogram and platelet count automated</td>
<td>$ 6.00</td>
<td>ALL</td>
</tr>
<tr>
<td>85610</td>
<td>Prothrombin time</td>
<td>$ 4.00</td>
<td>Hematology/Oncology/Cardiovascular Disease Physicians Only</td>
</tr>
<tr>
<td>86580</td>
<td>Skin Test, Tuberculosis, Intradermal</td>
<td>$ 7.00</td>
<td>ALL</td>
</tr>
<tr>
<td>86780</td>
<td>Skin Test, Tuberculosis, Intradermal</td>
<td>$ 3.20</td>
<td>Medicaid/Healthy Kids</td>
</tr>
<tr>
<td>87081</td>
<td>Culture, presumptive, pathogenic organisms, screening</td>
<td>$ 5.00</td>
<td>ALL</td>
</tr>
<tr>
<td>87804</td>
<td>Influenza Immunoassay</td>
<td>$ 11.50</td>
<td>Medicaid/Healthy Kids</td>
</tr>
<tr>
<td>87880</td>
<td>Streptococcus group A with direct optical observation</td>
<td>$ 5.00</td>
<td>ALL</td>
</tr>
</tbody>
</table>

All preadmission laboratory testing should be performed by a contracted lab. For members scheduled for elective admission, all preadmission diagnostic work-ups including lab, radiology, and supporting specialty consultations, must be referred to free-standing contracted Providers. If needed, lab services may be performed at that facility within seven (7) days of the event. Any laboratory service required prior to the seven (7) days must be performed as described above.

**CLIA Certification**

Physician office laboratories must hold either a CLIA certificate or a CLIA waiver to perform laboratory tests for members. When billing for laboratory services, please be sure to include your CLIA number on the claim form.
Section 10 – Claims, Billing, Capitation & Encounters

Providers shall submit claims in accordance with applicable state and federal laws. Untimely claims will be denied when they are submitted past the timely filing deadline. Unless otherwise stated in the Provider agreement, the following guidelines apply:

Timely Filing & Prompt Pay Guidelines Grid

<table>
<thead>
<tr>
<th>Provider / Claim Type</th>
<th>Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid participating and non-participating Providers</td>
<td>Provider shall mail or electronically transfer (submit) the claim within 365 days after the date of service or discharge from an inpatient setting or the date that the provider was furnished with the correct name and address of the Managed Care Plan. When the Managed Care Plan is the secondary payer, the provider must submit the claim within ninety (90) calendar days after the final determination of the primary payer.</td>
</tr>
<tr>
<td>Late charges/corrected claim (corrected coding, NDC, type of submission indicator)</td>
<td>Provider shall have the opportunity to correct any billing or coding error within 365 days of denial related to any such claim submission</td>
</tr>
<tr>
<td>Return of requested additional information (itemized bill, ER records, med records, attachments)</td>
<td>A Provider must submit any additional information or documentation as specified, within thirty-five (35) days after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Coventry cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)</td>
</tr>
</tbody>
</table>

Coordination of Benefits

Coordination of Benefits (“COB”) provision applies when a member has health care coverage under more than one plan. In the event that The Plan is the secondary payer, coordination of benefit claims must be submitted within ninety (90) days after final determination by the primary organization as evidenced by the primary carrier’s Explanation of Payment (EOP) or Explanation of Benefits (EOB) as required under applicable law and regulation. (See Florida statute 641.3155(2)). All explanations of payment or denials from the member’s primary carrier must be provided with the claim. Information should be sent to:

<table>
<thead>
<tr>
<th>Attn: Medicaid &amp; Healthy Kids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry</td>
</tr>
<tr>
<td>ACS</td>
</tr>
<tr>
<td>P.O. Box 7403</td>
</tr>
<tr>
<td>London, Kentucky 40742</td>
</tr>
</tbody>
</table>
Claim Status
You may use The Plan’s website at [www.directprovider.com](http://www.directprovider.com) to check the status of claims with dates of service within the last year (365 days).

How to Read Your Remittance Advice
Below are detailed explanations of the fields on the remittance advice to aid you in reading your remittance advice.

### Remittance Advice Summary - COVENTRY HEALTH CARE

**Provider:** 123456: DOE FAMILY PRACTICE

#### Claim Detail

- **Patient Name** – The name of the member who received the services
- **Account #** - Patient account number taken from the claim submission
- **Place of Service** – Identifies the type of facility where the services were provided, e.g., outpatient, hospital, office, etc.
- **Member #** - Coventry identification number for the member receiving services
- **Date Received** - The date the claim was received by The Plan
- **Processed Date** – The date the claim was processed in The Plan’s system
- **Claim #** – A unique number assigned during the claim imaging process. Please provide this number when making claim inquiries to assist in the review process
- **Auth #** -- The number that The Plan assigns to the referral associated with the claim, if applicable.
- **Claim Provider** – Identifies the name of the Provider in the HIPAA compliant format, otherwise known as who performed and billed the service.

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**Questions concerning claims status, benefits and appeals should be directed to Customer Service at 1-XXX-XXX-XXXX.**
• **Carrier** – The information in this field may vary by product and account. It indicates the entity responsible for funding the claim.

• **Network/Division** – Division of referring physician, if a referral is applicable. May also signify network accessed

• **Product** – Indicates which one of the The Plan products applies to the coverage for the member, e.g., HMO-Commercial, PPO, etc.

• **Service Dates** – Dates of service corresponding to each procedure code. Dates are listed from the first date the member received the service from the Provider (from date) through the last date the member received the service from the Provider (to date), as billed on the claim.

• **Procedure Code** – Code pertaining to the procedure performed and billed by the Provider on the corresponding service date(s)

• **Mod Cd** – Indicates the modifier for the procedure code and procedure description, if applicable

• **DRG/APC** – Reflects the DRG billed by the provider, not necessarily the DRG used to process the claim.

• **Procedure Description** – Describes the procedure performed for the procedure code indicated

• **CAP Y** – Yes, Indicates the claim line was adjudicated as a result of a capitated agreement.

• **CAP N** – No, indicates the claim line was adjudicated as a result of a fee for service agreement

• **Total Charges** – The amount billed for the procedure(s) performed on the corresponding service dates(s)

• **Allowed Amount** – Amount of billed charges less any ineligible amounts

• **Ineligible Amount** – Amount that is not covered/reimbursable or is in excess of the Provider’s contracted rate and for which the Provider is responsible

### Editing Guidelines

The Plan uses multiple editing systems to process claims through its practice management application. These systems are configured to comply with applicable state and federal regulations, with respect to timely filing, coding combinations, maximum units, place of service and other editing guidelines. Claim denials resulting from editing that conflict with contractual obligations will be reviewed by our Clinical Editing Review Committee and a payment determination will be made based on the Provider’s agreement and correct coding initiatives.

A reduction in payment as a result of claims policies and/or editing procedures is not an indication that the service is a non-covered service.

**Note:** *Claims processed after the implementation date, regardless of date of service, will process according to the most recent version. No retrospective claim payment changes are made for processing changes that are a result of new editing rules.*

### High Dollar Claims *(with expected payable amounts over $50,000)*

All claims submitted to The Plan with an **expected payable amount** of over $50,000 ("high dollar") require the accompaniment of an itemized statement. High dollar claims not accompanied by itemization are subject to denial. If a hospital provider receives such a denial, the claim should be marked as a resubmission and resubmitted with the itemization for processing.

The purpose of the itemization review is to identify items billed under routine services in an inpatient setting that are not separately billable. Such items include but are not limited to:

- Minor medical and surgical supplies such as Band-Aids, cotton balls, Q-tips, swab sticks, drapes, saline solutions irrigation/flush, syringes, gloves, drapes, bed linen, gowns.
- Other identified nursing charges.
- IV nursing care, procedural charges for an IV flush and or administration is considered a routine cost.
- Equipment permanently stored or housed in a room such as cardiac/heart monitor in ICU/CCU, BP monitor, resp. ETCO2 equipment.
- Continuous pulse ox monitoring in critical care or step down units.
- Personal items such as slippers, lotions, powders, deodorant, admission kits (except MD), tooth brushes, denture care kits, under pads.

**National Provider Identifier (NPI)**

NPI is the standard unique health identifier for health care Providers adopted by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996. You may apply for an NPI number online at [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov).

Providers are required to submit their NPI on every claim.
Section 11 – EDI Claim & Encounter Submissions

An encounter or a claim is an interaction between a patient and Provider (MCO, HMO, rendering physician, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient. Encounters can be reimbursed to the provider for fee for service or capitation by the health plan.

Providers must have a 9 digit Medicaid ID prior to submitting claims/encounters to the Health Plan.

Providers can register with the State of Florida using the link below:

http://portal.flmmis.com/flpublic/Provider_ProviderServices/Provider_Enrollment/Provider_Enrollment_EnrollmentForms/tabid/58/Default.aspx?desktopdefault=%20

Providers who are required to bill on the CMS-1500 Claim Form or Professional EDI submission:

Physicians
Ambulance, Land and Air
Ambulatory Surgical Centers
Assistive Care Providers
Audiologists
Birthing Centers
Child Health Check-Up Providers
Children at Risk Targeted Case Management
Children’s Health Services Targeted Case Mgmt
Management
Chiropractors
Community Mental Health Services Providers
County Health Departments
Advanced Registered Nurse Practitioners
Therapy Providers

County Health Department Certified Match
Dentists
Durable Medical Equipment
Early Intervention Services
Federally Qualified Health Centers
Hearing Aid Specialists
Home and Community-Based Waiver Services
Home Health
Independent Laboratories
Licensed Midwives
Medicaid Certified School Match
Medical Foster Care
Mental Health Targeted Case Management

Providers who are required to bill on the UB-04 Claim Form or Institutional EDI submission:

Freestanding Dialysis Centers
Hospitals
Hospital-Based Skilled Nursing Facilities
Hospice
Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
Nursing Facilities
State Mental Hospitals
Rural Swing Bed Providers
Statewide Inpatient Psychiatric Program (SIPP) Waiver providers

In support of Health Insurance Portability and Accountability Act (HIPAA) and its goal of administrative simplification, we encourage physicians and medical Providers to submit claims electronically. Electronic claims submission can have a significant, positive impact on the productivity and cash flow for your practice.
Electronic claim submission to The Plan payers is easy to establish. **Contact your practice management system vendor or clearinghouse to initiate the process.** Electronic claim submissions will be routed through Emdeon who will review and validate the claims for HIPAA compliance and forward them directly to The Plan.

Providers can also submit directly to Emdeon. Emdeon will provide the electronic requirements and set-up instructions. Providers should call (800) 215-4730 or go to [www.emdeon.com](http://www.emdeon.com) for information on direct submission to Emdeon.

EDI claim submitters should review the electronic claim submission requirements below:

1. **EDI Specifications:** The 837 claim transaction is utilized for electronic professional and institutional claims and encounters. We use the ASC X12N 837 Professional Health Care Claim and the ASC X12N 837 Institutional Health Care Claim implementation guides. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website at [www.wpc-edi.com](http://www.wpc-edi.com).

   This document contains clarifications and payer specific requirements related to data usage and content with submitting an EDI claims to The Plan. Please note that this document is intended to list only those elements where payer specific requirements or clarifications apply.

2. **Specific Payer Edits at Emdeon:** All EDI claims submitted through Emdeon will be subject to these specific payer edits (unless indicated for one transaction only) that are in place at Emdeon. Submitters will receive these types of rejections on their level 1 payer rejection reports.

   - The insured id must be at least two characters in length or the claim will reject
   - To allow zero dollar line charges and zero dollar claim charges
   - The billing Provider id may not contain a value of 999999999 or the claim will reject
   - If the procedure code begins with 0, then anesthesia minutes are required or the claim will reject. Excluding procedure code is 01995 or 01996 then service units are required and the anesthesia minutes should contain 00 or the claim will reject. If the procedure code begins with a 0 and ends with T, then service units are required and the anesthesia minutes should contain 00 or the claim will reject.
   - If the procedure code does not begin with a 0, then service units are required and the anesthesia minutes should contain 00 or the claim will reject.
   - The discharge hour must contain a numeric value of 00-23 or 99 if the batch type contains an inpatient value of x10, x11x14 or x17 and the statement period from date is equal to the statement period thru date.

3. **EDI Acknowledgement and Reject Reports:** For every claim filed electronically, the Provider should monitor whether or not that claim has been rejected by reviewing EDI acknowledgement and reject reports on a regular basis. The following reports should be monitored regularly:
• **Initial reject report (Emdeon report Rpt 05 or equivalent vendor report)** - This is a report that shows claims rejected by Emdeon that were not forwarded to Mail Handlers Benefit Plan. These claims should be corrected and re-submitted electronically.

• **Initial accept report (Emdeon Envoy Report Rpt 04 or equivalent vendor report)** - This is a report that shows Emdeon accepted the EDI claim and forwarded it for processing.

• **Payer rejects report (Emdeon Report Rpt 11 or equivalent vendor report)** - This report states why The Plan rejected the claim. These claims should be corrected and re-submitted electronically.

**Monitoring Your EDI Reports**

Please note that claims appearing on the initial reject report have not met the initial clearinghouse criteria approved by The Plan and have not been sent to The Plan for adjudication. Any claims appearing on this report must be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

It is also important to note that a claim can pass the clearinghouse edits and be displayed on the initial accept report, but still be rejected. Claims rejected will appear on the payer reject report. Any claims appearing on this report should be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

**Timely Filing** - The Plan must accept a claim within its timely filing limit or it will be denied for untimely filing. If you are not receiving the described clearinghouse and payer reports on a regular basis, please contact your clearinghouse or Emdeon. A Provider can avoid timely filing issues through understanding and regular monitoring of EDI Reports. This process will help to ensure all rejected claims are re-filed timely and electronically.

**Common Rejection Reason**

Review the following tips for assistance with resolving the most common rejections received by Providers. The most common claim reject reason is “Member not found.” Use the Coventry secure Provider portal, www.directProvider.com, Emdeon, or an integrated solution through your vendor or clearinghouse to verify/validate member’s eligibility prior to submitting claims.

- **Member Identification Number** - Submit the 10 or 11 digit number as displayed on the patient’s ID card.

- **Patient Date of Birth** - Submit a valid date of birth for the patient.
  - Do not send "00" for the month or date
  - Do not send dummy dates such as "17760704"
  - Do not send a date of birth greater than the date of service

- A claim will be rejected if a valid date of birth does not match the date of birth on file in the system. If this is the case, please verify the patient date of birth with the patient or policyholder.

- **Date Format** - Submit all dates in the following format CCYYMMDD unless otherwise specified.
  - Submit valid dates of service
  - Do not submit future dates of service

- **Monetary Amount Format** - Include the decimal point in all monetary amounts unless otherwise specified.
  - Do not submit negative dollar amounts
- **Coding Detail** - Consider the following when verifying service codes and/or modifiers that have been rejected.
  - Submit service codes and modifiers appropriate to the age and gender of the patient
  - Submit service codes and modifiers appropriate to the date of service
  - Submit service codes to their greatest level of specificity

**EDI Assistance**

The **Clearinghouse** - typically, your first point of contact for resolving an EDI issue is your practice’s specific clearinghouse or vendor.

**Emdeon** - The Emdeon customer service center can track all EDI submissions received by them. Emdeon also maintains the status message returned on an EDI claim from the health plan. This information is readily available for forty-five (45) days after the submission. Information on older submissions is also available but will require being forwarded to their research division for follow-up. Emdeon customer support can be reached at **(877) 469-3263.** Additionally, Emdeon has a new web-based application, Vision for Claim Management that compiles claim information received and generated during claim filing and processing. It is in an easy to use application for tracking EDI claim submissions. For more information and registration for Vision for Claim Management, go to [http://transact.emdeon.com/editrx_services.php](http://transact.emdeon.com/editrx_services.php)

The Plan staff is available to assist you with electronic filling concerns as they relate to our submission requirements. Please contact us at (302) 283-6570 or via email at [EDIClaims@cvty.com](mailto:EDIClaims@cvty.com).

**Medical Necessity Reconsideration (Pre-Service)**

The Plan is not obligated to pay for unauthorized services. If the Provider does not agree with the determination and the matter cannot be resolved informally, The Plan maintains a pre-service appeals process through which all Providers (physician, facility, or ancillary) may appeal, on behalf of a member, a medical management issue or benefit determination. This process also includes provisions for an urgent review process in which the Provider can expect a determination within 72 hours of initiating the request.

If a Provider does not agree with a denial for lack of medical necessity, he/she may request a reconsideration of the decision. This may be done by providing additional information in one of two ways.

- A Peer to Peer Review with the Medical Director who made the decision may be requested by calling the Health Services Department at (800) 292-4470 within 24 hours or one working day of the denial, or;
- A request for reconsideration may be made by providing additional information by phone at (800) 292-4470, by fax at (888) 399-1831, or mail to:

**Coventry Health Care**
Attn: Health Services/Appeals Unit
1340 Concord Terrace
Sunrise, FL 33323
**Important Information About Medicaid Member Appeal Rights**

A Medicaid member may file a Medicaid grievance, or a Provider acting on the Medicaid members behalf with written authorization, may file a Medicaid grievance. Medicaid grievances can be filed either orally or in writing and must be filed within one (1) year after the date of occurrence that initiated the grievance. The address and telephone number to contact the Grievance and Appeals department is:

Coventry Health Care of Florida, Inc.  
Attention: Appeals and Grievance  
1340 Concord Terrace, Sunrise FL 33323  
(800) 441-5501 (toll free)

You can contact the Customer Service Department to file a grievance and request the form by calling (800-441-5501) Monday through Friday 8:00 a.m. – 7:00 p.m. Eastern Time. The Plan and/or the Provider must give the Medicaid member reasonable assistance in completing the forms and other steps, including but not limited to providing interpreter services and interpreter capability.

The Grievance Coordinator will send an acknowledgement letter within three (3) business days of the receipt of the Medicaid grievance. The Medicaid grievance will be reviewed as expeditiously as the Medicaid member’s health requires, or in a reasonable length of time not to exceed ninety (90) days from initial filing by the Medicaid member, or Provider acting on their behalf. If an extension is necessary, The Plan will notify the Medicaid member of the delay, which is not to exceed fourteen (14) calendar days.

Information about the Subscriber Assistance Program (SAP) process, including an explanation that a review by the SAP must be requested within one (1) year after the date of the occurrence that initiated the appeal, how to initiate a review by the SAP and the SAP address and telephone number:

**Agency for Health Care Administration Subscriber Assistance Program**

Building 1, MS #26 2727 Mahan Drive, Tallahassee, FL 32308  
(850) 412-4502  
(888) 419-3456 (toll-free)

**Request for a Reconsideration (Appeal) for Medicaid Members**

A Medicaid member may file an appeal, or a review of a Medicaid action (denial in whole or part of a requested service). The Medicaid member, or Provider acting on their behalf, may file an appeal within thirty (30) calendar days of the date of the action. Any oral requests to appeal a Medicaid action are treated as appeals and The Plan will confirm the appeal in writing, unless the Medicaid member or Provider requests an expedited resolution.

For decisions that involve an appeal of a denial that is based on medical necessity, a Medicaid grievance regarding the denial of an expedited resolution of an appeal, or a grievance/appeal that involves clinical issues, the decision maker will be someone other than the person involved in making the initial determination, and who has the clinical expertise in the Medicaid members condition or disease.

The Medicaid Member or their representative will have an opportunity to review the case file, including medical records and any other documents and records.
Expedited Reconsideration (Expedited Appeal) for Medicaid Members
The Plan has an expedited review process for appeals when The Plan determines, or the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Medicaid member’s life or health or ability to attain, maintain, or regain maximum function.

The Medicaid member or Provider may file an expedited appeal either orally or in writing. No additional Medicaid member follow-up is required.

Further Rights for Review/Medicaid Fair Hearing for Medicaid Members
The Plan’s Grievance and Appeal processes state that the Medicaid member has the right to request a Medicaid fair hearing in addition to pursuing The Plan’s grievance process. A Provider acting on behalf of the Medicaid member and with the Medicaid member’s written consent may request a Medicaid fair hearing. A Medicaid grievance taken to the Medicaid fair hearing process will not be considered by the subscriber assistance program.

The Medicaid member or Provider may request a Medicaid fair hearing within ninety (90) days of the date of the notice of action (or denial of service). To request a Medicaid fair hearing, the Medicaid member or Provider must contact:

Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, FL 32399-0700

Coventry is required to continue the Medicaid member’s benefits while a Medicaid fair hearing is pending if:

(a) The Medicaid fair hearing is filed timely, meaning on or before the latter of the following:
   (i) within ten (10) days of the date on the notice of action;
   (ii) the intended effective date of Coventry’s proposed action;
(b) The Medicaid fair hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;
(c) The services were ordered by an authorized Provider;
(d) The authorization period has not expired; and
(e) The Medicaid member requests an extension of benefits.
**Section 12 – Grievances and Appeals**

A **grievance** is a formal complaint about a doctor or service. A **grievance** may be filed orally or in writing within one year of the incident.

An **appeal** is a formal complaint about a service that is denied. An **appeal** may be filed within thirty (30) days of receiving the notice of action. If the appeal is filed orally (except for an expedited appeal), it must be followed up with a written notice within ten (10) calendar days of calling in the appeal.

A Medicaid member may file a Medicaid grievance or appeal, or a Provider acting on the Medicaid member’s behalf with written authorization, may file a Medicaid grievance or appeal.

The address and telephone number to contact the Grievance and Appeals department is:

Coventry Health Care of Florida, Inc.  
Attention: Appeals and Grievance  
1340 Concord Terrace, Sunrise FL 33323  
(800) 441-5501 (toll free)

You can contact the Customer Service Department to file a grievance or appeal and request the form by calling (800-441-5501) Monday through Friday 8:00 a.m. – 7:00 p.m. Eastern Time. The Plan and/or the Provider must give the Medicaid member reasonable assistance in completing the forms and other steps, including but not limited to providing interpreter services and interpreter capability.

The Grievance Coordinator will send an acknowledgement letter within three (3) business days of the receipt of the Medicaid grievance or within five (5) days of getting an appeal.

The Medicaid grievance will be reviewed as expeditiously as the Medicaid member’s health requires, or in a reasonable length of time not to exceed ninety (90) days from initial filing by the Medicaid member, or Provider acting on their behalf. If an extension is necessary, The Plan will notify the Medicaid member of the delay, which is not to exceed fourteen (14) calendar days.

The Medicaid appeal will be reviewed as expeditiously as the Medicaid member’s health requires, or in a reasonable amount of time, not to exceed forty five (45) days.

An “expedited appeal” can be requested if the provider or member feels that waiting 30 days for a decision could put the member’s life, health or ability to attain, maintain, or regain maximum function in danger. This can be done by phone or in writing, but you need to make sure to ask for the appeal to be expedited. We may not agree that the appeal needs to be expedited, but we will let you know of our decision. If we do not expedite the appeal, it will be processed under normal time frames. If we do expedite the appeal, we will advise of the decision within three (3) business days after receiving the expedited appeal request.

For decisions that involve an appeal of a denial that is based on medical necessity, a Medicaid grievance regarding the denial of an expedited resolution of an appeal, or a grievance/appeal that involves clinical issues, the decision maker will be someone other than the person involved in making the initial determination, and who has the clinical expertise in the Medicaid member’s condition or disease.
The Medicaid Member or their representative will have an opportunity to review the case file, including medical records and any other documents and records.

**How to Ask for a Fair Hearing**
A member does not need to go through the appeal process before asking for a Fair Hearing. A fair hearing can be requested by phone or in writing. A Provider may request a hearing on behalf of a member, but the member must give written approval to the provider to request a hearing on their behalf. A Fair Hearing can be requested any time up to 90 days from the date of the notice or action, or up to 90 days after getting our decision on the member’s appeal. A Fair Hearing can be requested by calling (850) 488-1429 or in writing to:

Department of Children and Families  
Office of Appeal Hearings  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
FAX: (850) 487-0662  
EMAIL: Appeal_hearings@DCF.state.fl.us

**NOTE:** MediKid enrollees and Florida Healthy Kid enrollees are not eligible to participate in the Medicaid Fair Hearing Process

**How to Ask for Services to Continue:**
If a member was receiving a service that was reduced, suspended or terminated, they have the right to keep getting those services until a final decision is made in an appeal or Fair Hearing. The member MUST file the appeal or request for Fair Hearing within the following time frames:

*For an appeal:*
File the appeal with Coventry Health Care not later than ten (10) days from the date the Notice of Action letter was mailed OR no later than 10 days after the first day our action will take place, whichever is later. The appeal can be requested by phone, but must be followed up with a request in writing. **The member MUST tell us they want their services continued.**

*For a Fair Hearing:*
The member must file the request with the Office of Appeal Hearings no later than ten (10) days after the notice of action letter was mailed or before the first day the action will take place, whichever is later. **The member should tell the hearing officer they want their services to continue.**

If services are continued and our decision is upheld in an appeal or Fair Hearing, we may ask that the member pay for the cost of the services. **WE will not take away the member’s Medicaid benefits. We cannot ask the member’s family or legal representative to pay for the services.**
Right to Request a Review from the Subscriber Assistance Program

If a member does not like our appeal decision, they have one year after receiving the final decision letter to request a review by the Subscriber Assistance Program (SAP). **The appeal process must be finished first. If the member, or provider on behalf of a member with written permission, asks for a Fair Hearing, they cannot have a SAP review.**

To ask for a SAP review, the member should call (999) 419-3456 (toll free) or send the request to:

Agency for Health Care Administration  
Subscriber Assistance Program  
2727 Mahan Drive, Mail Stop #26  
Tallahassee, FL 32308
**Section 13 - Provider Participating Status**

**Dispute Resolution**

The Plan has a process for participating Providers to resolve issues between the participating Provider and The Plan that may result in a change in network status of the Provider, as such network status change relates to The Plan’s review of the Provider's professional competency and/or conduct or clinical quality. A Provider may be denied continued participation status for quality concerns based on the competence or professional conduct of a Provider, which affects or could affect the health or welfare of a patient or patients.

Examples of such quality concerns include but are not limited to:

- Evidence of substandard treatment rendered to patients
- Malpractice judgments/settlements
- In any instance where corrective action will be required to be reported to the National Provider Data Bank
- In any instance where a Provider’s Contract with Coventry is terminated for cause under the terms of the Contract
- Current Medicare or Medicaid sanctions
- Loss of accreditation or certification status if a facility or ancillary Provider

Prior to taking any final action to deny continued participation status to a Provider for quality concerns, the Provider will be entitled to pursue the appeal process.

If the Credentialing Committee has made the determination to not renew a Provider’s reappointment for reasons based on quality concerns, the Provider shall be notified in writing by the Medical Director of the decision and the reasons for it. The Provider may request an appeal, within thirty (30) days of receipt of the decision letter. The Provider must make this request to the Medical Director in writing.
Section 14 – Overpayment Recovery

If a claim is overpaid, the Provider will receive a letter via U.S. mail from The Plan requesting the return of monies paid in error in accordance with Florida statute.

Providers are able to access and track their overpayment recovery detail through our website at www.directProvider.com under the “Providers’ section.” If there are any questions about the information in the notice, on the website or concerns about an explanation of payment entry for a negative amount, please email The Plan’s Financial Recovery Department at Financial.RecoverySF@cvty.com or via mail to:

Recovery Operations
P.O. Box 7247-7427
Philadelphia, PA 19170-7427
Section 15 – Credentialing

Credentialing activities follow the guidelines defined by various accrediting organizations, CMS as well as state and federal regulations.

Provider categories requiring full credentialing based on these stated guidelines include:

- Physicians (MD, DO)
- Dentists (Oral Maxillofacial – DDS/DMD)
- Chiropractors (DC)
- Podiatrists (DPM)
- Physical Therapists/Occupational Therapists/Speech Therapists (ONLY if individually contacted and listing in the Provider directories)
- Various allied health and behavior health Providers, as defined by Coventry, and
- Additional Providers who hold independent relationships or Contracts with Coventry and/or are listed in Provider directories, or as required by a specific state statute.

Providers may complete The Plan’s Provider application. Use of The Council for Affordable Quality Healthcare, Inc. (CAQH) universal application, which is free to the Provider and available statewide, is encouraged to support electronic submission. Providers may access www.caqh.org to register directly.

The requirements for Provider credentialing are:

- Complete executed appropriate application
- Verification of current licensure in the state(s) where the Provider has a practice location and/or hospital privileges/affiliation
- Evidence of good standing with state regulatory bodies
- Absence of federal and state sanctions verified through the EPLS and NPDB
- OIG Form – Ownership & Controlling Interest Worksheet
- Absence of sanctions verified through OIG/LEIE
- DEA or state controlled substance license (CDS/BNDD) in every state in which a Provider sees Coventry Members as defined by practice location and hospital affiliation
- Liability insurance (by attestation or by a copy of liability insurance policy declaration sheet, or as required by Florida statute 458.320)
- Verification of education, either by board certification or education verification
- Current hospital affiliation
- At least a 5-year uninterrupted work history (or period of time required by state statute)
- Completion of survey questions with explanations for any “yes” answers
- Current signed attestation/release; and
- Site visit (PCPs and OB/GYNs)

Practitioners Rights:

Practitioners have a right to correct erroneous information submitted by another source. Information that differs substantially from that submitted by provider will require staff to notify provider for clarification/correction, including variations from Provider reported information on malpractice history, licensure actions or board certification status.
Practitioners may review information submitted to support their credentialing application, including any information received from outside sources, with the exception of references, recommendations or other peer review protected information.

Practitioners may receive the status of their credentialing or recredentialing application, upon request

**Board Certification:**
Board certification is not a requirement for network participation. However, Providers may be ineligible for participation in specific regulated products which require the Provider to be board certified, e.g. Florida Healthy Kids.

**Facilities** are credentialed by license, not by TIN and must utilize The Plan’s facility application. Urgent Care Centers are subject to credentialing at the facility level only; Providers in these centers are not individually credentialed. Additional categories may be added based on state requirements, regulations and/or accreditation standards. All facilities require evidence of one of the following: accreditation from a recognized approved entity, results of a survey done by the state, CMS audit or CMS Certification.

Facility categories requiring full credentialing based on these stated guidelines include:

<table>
<thead>
<tr>
<th>• Hospitals</th>
<th>• Laboratories</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Free standing ambulatory surgery centers</td>
<td>• Nursing Homes</td>
</tr>
<tr>
<td>• Home Health Agencies</td>
<td>• Skilled Nursing Facilities</td>
</tr>
<tr>
<td>• Home IV/Infusion Services</td>
<td>• Urgent Care Centers</td>
</tr>
<tr>
<td>• Retail Clinics (“Minute Clinics”)</td>
<td>• Hospices</td>
</tr>
<tr>
<td>• Behavioral health Facilities including in-patient, residential and/or ambulatory</td>
<td>• End Stage Renal Disease Facilities (ESRDs)</td>
</tr>
<tr>
<td>• Physical Therapy/Occupational Therapy/Speech Language Therapy</td>
<td>• Comprehensive Outpatient Rehabilitation Facilities</td>
</tr>
</tbody>
</table>

The requirements for facility credentialing are:
- Complete executed application
- Verification of current licensure in the state where the facility treats Plan members
- Evidence that the facility is in good standing with state regulatory bodies
- Absence of federal and state sanctions verified through the OIG/LEIE
- Liability insurance
- Current signed attestation/release; and
- Copy of W-9

**Re-Credentialing**
Providers and facilities are subject to re-credentialing every three years or as applicable based on state standards. Initiated by the CVC within 180 days of the current expiration date, the process follows the same as initial credentialing with the exception of primary source verification of education and work history. Providers and facilities non-compliant with the re-credentialing requirements may be terminated from The Plan’s network.

**Dual Specialties**
Participation in two or more specialties may be granted based on The Plan’s business need and supported by verifiable training in the specialties requested.
Ongoing Monitoring
The Plan routinely monitors Providers and facilities ensuring any changes in licensure status, sanctions or other adverse actions are reviewed by the Credentialing Committee. Providers or facilities with a license suspension or revocation are subject to termination from The Plan’s network.
Section 16 – Pharmacy

The Formulary
The purpose of The Plan’s formulary is to encourage use of the most cost-effective drugs. The formulary is necessary because the cost of prescription drugs, especially specialty drugs, is rising faster than other health care costs. Some of the reasons for this trend include:

- More advertising for newer high-cost drugs
- An aging population that uses more drugs
- The high cost of research and development for new drugs

Without a formulary, The Plan members would end up paying more for health care coverage, due in part, to rising drug costs. Our formulary allows us to continue providing cost-effective pharmacy benefits.

The Plan formularies are developed and maintained by a committee of doctors and pharmacists. The Pharmacy & Therapeutics (P&T) Committee studies new drugs and new information for existing drugs. They keep up-to-date on the newest developments in medicine, and they continual improve our formularies based on the latest research, including the following (where applicable):

- Drug labeling
- Clinical outcome studies from peer-reviewed published medical literature
- Standard drug reference compendia
- Regulatory status
- Evidence-based guidelines published by medical associations, government agencies or national commissions
- Views of professionals in relevant clinical areas
- Other related factors

Our P&T Committee determines how drugs will be covered on the formulary based on the following criteria:

- **Efficacy**: Preferred drugs must be as good as, or superior to, other currently available alternatives for most of the population.
- **Safety**: Preferred drugs must be as safe as, or safer than, other currently available alternatives.
- **Health Outcomes (when available)**: Preference is given to drugs which have been shown to improve overall health outcomes.
- **Drug Interactions**: Preferred drugs must have similar or less potential for drug interactions compared to other currently available alternatives.
- **Pharmacokinetics**: Consideration is given to drugs with evidence showing that less frequent dosing increases patient compliance and outcomes.
- **Contraindications**: Consideration is given to drugs that do not have factors which would restrict their use of specific patient populations.
- **Cost**: When two or more drugs produce similar clinical results, cost is taken into account in determining whether a drug makes it onto our formulary. **Note**: Formulary decisions are based on cost differences only after safety; effectiveness, possible side effects, and therapeutic need have been established.
- **Generic availability**: Decisions to add generics to the formulary are based on safety, cost, established equivalence to the brand name, and compliance with existing drug contracts.
Comments and suggestion on the formulary are welcomed and should be directed to The Plan’s Pharmacy department. Doctors may submit a written request to have a medication added to the formulary by submitting a written request to the attention of The Plan’s P&T Committee. At a minimum, written requests should include:

- Advantages and disadvantages of the drug compared to current formulary alternatives
- Indications for use, efficacy and a review of side effects

We do not require that doctors only prescribe preferred formulary drugs. However, members may save time and money if a prescribed drug is on The Plan formulary. In most case, there are at least two formulary alternatives to choose from.

You can find the formulary, including any restrictions and preferences, as both a printable document and a searchable database on our website. The formulary applies only to outpatient prescription medications dispensed by participating pharmacies. It does not apply to inpatient medications or the medications obtained from and/or administered by doctors, unless exceptions are noted, all dosage forms (e.g., tablet, capsule, liquid, topical) and strengths or a formulary drug are included.

While new drugs may be added to the formulary throughout the year, we try to remove them only twice a year (generally January 1 and July 1). A summary of the most recent formulary changes can be found on our website. In addition to the drug limitations and restrictions called out in the formulary, certain classes of drugs (such as those for cosmetic uses or smoking cessation) may not be covered. Members should then refer to their benefit document, or call Customer Service at the number on their ID card, to determine which drugs are excluded under their benefit plan.

Depending on the patient’s prescription drug benefit (example: closed formulary), doctors may request an exception to the formulary. In fact, doctors can request a coverage exception for any drug that he/she considers to be medically necessary by following the steps outlined under the section of this document entitled “Processes for Requesting a Medication Coverage Exception.”

**Prior Authorization**

On of The Plan’s tools to help manage rising prescription drug costs is to require prior approval, or authorization, before drugs are covered. Drugs which require prior authorization are often not suggested as the first-line treatment option, and/or may have limited diagnoses for which they are recommended. Prior authorization may also be required for drugs that are very expensive. The prior authorization program helps to ensure that drugs are used in a safe, appropriate and cost-effective manner.

Our P&T Committee determines which drugs require prior authorization and the criteria for coverage. Drugs that require prior authorization will be denied at the member’s pharmacy until The Plan has reviewed the necessary clinical information provided by the doctor and approved coverage.

**Step Therapy**

Step therapy is a form of prior authorization. It involves an electronic review of a member’s drug history to ensure that appropriate generic or first-line drugs have been tried already. If the member has already tried the preferred drug(s), the claim will be process as normal with the appropriate copayment. If the preferred drug(s) are NOT in the member’s drug history, the claim will reject at the pharmacy and the doctor will need to provide additional clinical information to the health plan for further review.
**Which drugs require prior authorization or step therapy?**

You can identify drugs that require prior authorization or step therapy by referring to our printable formulary document, online searchable formulary, or prior authorization or step therapy lists. Each of these resources is available on our website. Prior authorization and step therapy criteria and specific coverage request forms can also be found on our website.

**Generic Substitution/Therapeutic Interchange**

Depending on a member’s benefit plan, **generic substitution** may be required for brand-name drugs where the U.S. Food and Drug Administration has determined that the generic is equivalent to the brand. However, this requirement is based on the availability of the generic and state regulations regarding drug product selection. If a doctor states that the brand is required, or a member requests the brand when a generic equivalent is available, the member may have to pay a higher out-of-pocket amount based on his/her benefit plan. Generic substitution is not required for brand drugs when slight differences in blood levels have been determined to cause reduced safety and/or efficacy (narrow therapeutic index drugs). Examples may include: Dilantin®, Tegretol®, Coumadin®, Lanoxin®, theophylline, and Synthroid®.

The Plan may offer a three-month program that waives copays as an incentive for members to switch to a preferred generic or over-the-counter drug. This program (Value Program) is a **voluntary therapeutic interchange** opportunity that may help members save money. If a member’s health plan and employer group participate in this program, they will receive a letter after the first time they fill any eligible non preferred drug. This letter will offer three months of $0 copay if the member chooses to contact your doctor and get a new prescription for the preferred alternative. The list of Value Program Select Target drugs, including the preferred alternatives, is available on our website.

**Specialty Drugs**

Specialty drugs are defined by the health plan. They are typically high-cost drugs, including, but not limited to, the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Characteristics of specialty drugs are:

- Used to treat and/or diagnose rare and complex diseases
- Require close clinical monitoring and management
- Frequently require special handling
- May have limited access or distribution

Specialty drugs require prior authorization and are subject to quantity limits, unless otherwise indicated. Refer to the formulary to identify specialty drugs and to determine if prior authorization and/or quantity limits apply. The formulary is available on our website. The Plan has contracted with **Aetna Specialty Pharmacy®** to provide most of our specialty drugs. Once authorization has been approved, a doctor can call a prescription in to Aetna Specialty Pharmacy at **866-782-2779**. Members should refer to their health plan documents or call our Customer Service department with any questions regarding specialty drug coverage.
Process For Requesting A Medication Coverage Exception
A doctor, or their appointed representative, can request a medication coverage exception on behalf of a patient who is a Plan member by:

1. **Calling** the Pharmacy Call Center at **877-215-4098**. The Call Center will ask a number of clinical questions, and depending on the answer provided, coverage will either be approved or the caller will be given the opportunity to fax in additional information for further clinical review.
2. **Faxing** a letter of medical necessity, or the applicable prior authorization request form, to the Pharmacy Call Center at **855-799-2554**. You can obtain prior authorization request forms on our website or by calling your Provider Relations representative.
3. **Mailing** all clinical information related to the request to the attention of the Pharmacy Department at the member’s Plan.

Doctors should include the following information with all requests for medication coverage:
- Patient’s name
- Patient’s date of birth
- Patient’s member ID number
- Name, strength and closing schedule for the drug being requested
- Diagnosis for which the drug is being requested
- Any necessary supporting documentation (i.e., progress notes, laboratory results, published literature supporting safety/efficacy, etc.)
- All drugs previously tried for the diagnosis being treated and the reason for the failure

Pharmacy Benefit Information
The Plan members can get personalized, real-time prescription drug pricing information, by visiting My Online Services sm on our website. They can easily complete the following actions on My Online Services sm:

- Determine their financial responsibility for a drug, based on their pharmacy benefit
- Initiate the exceptions process for drugs that have restrictions
- Order a refill for an existing, unexpired mail-order prescription
- Find the location of an in-network pharmacy
- Conduct a pharmacy proximity search based on ZIP code
- Determine potential drug-drug interactions
- Determine a drug’s common side effects and significant risks
- Determine the availability of generic substitutes

Doctors should call their Provider Relations representative with any questions related to The Plan’s Pharmacy benefits.
Independent Contractor Relationship
In consideration of monthly premium payments made on behalf of Members, The Plan agrees to arrange for the delivery of health care services in accordance with and subject to the terms and conditions of the applicable member contract entered into between the members, or on the member’s behalf, and The Plan. Provider agrees The Plan, in so arranging for the delivery of health care services and supplies to members, provides such services or supplies through independently contracted Providers.

In accordance with the agreement, Provider and The Plan are independent contractors. The Plan shall not be liable for any negligent act or omission committed by a Provider or any Provider staff or hospital vendor who may from time to time, furnish services or supplies to members. Provider acknowledges and agrees that any decisions made by The Plan concerning appropriateness of setting or whether any service is covered are made solely for purposes of determining whether benefits are due under the applicable member contract, and not for purposes of recommending any medical treatment or non-treatment.