2016 Florida Provider Manual

“We are Ladies and Gentlemen, serving Ladies and Gentlemen”
Dear Provider:

Enclosed you will find the 2016 Leon Medical Centers Health Plans (LMCHP) Provider Manual. Upon receipt of this manual, please sign below and return this form to LMCHP by fax or mail to the following:

Leon Medical Centers Health Plans
Network Operations Department
8600 NW 41st Street, Suite 201
Doral, FL 33166

📞 305-646-3776 or
📞 305-631-5242
Fax: 305-646-3781

I acknowledge receipt of the Leon Medical Centers Health Plans Provider Manual. I agree to the terms and provisions of the manual along with all updates.

________________________________________
Signature of Provider                      Date

________________________________________
Print Name of Provider
INTRODUCTION

Leon Medical Centers Health Plans’ (LMCHP) Provider Manual is designed to provide Primary Care Physicians (PCP), Specialty providers, Ancillary providers and Facility administrators and their staff with a source of readily available information regarding the administration of our plan. The manual contains an overview of the product offered by LMCHP and provides administrative procedures for claims processing, referrals, prior authorizations and the Quality Management program.

This manual is intended for use by the staff of participating primary care physicians (PCP), specialists, hospitals and ancillaries, and the information contained herein should not be shared with anyone not directly related to the daily function of the above described entities. Participating PCPs, Specialists, Hospitals and Ancillaries are considered to be those providers which have contracted with LMCHP to provide services to our members.

Any comments or questions regarding the information contained in this manual should be directed to:

Leon Medical Centers Health Plans
Network Operations Department
8600 NW 41st Street, Suite 201
Doral, FL 33166
Medicare
Medicare is the federal program established by Title XVIII of the Social Security Act of 1965, as amended from time to time, which provides health care coverage for the aged and disabled. During the three months prior to an American citizen’s 65th birthday, the Social Security Office will send the individual information concerning enrollment in Medicare. There are four types of Medicare insurance:

- **Medicare Part A**: Provides inpatient hospital insurance
- **Medicare Part B**: Provides medical and outpatient hospital insurance, i.e. doctor visits
- **Medicare Part C**: Medicare Advantage Plans, i.e. LMCHP
- **Medicare Part D**: Prescription Drug plans

**Medicare Part A** is made available to individuals who are at least 65 years old, certain disabled persons, persons with End Stage Renal Disease (if diagnosed after enrollment), and person who meet Medicare eligibility requirements. Part A is the basic part of the health insurance program covering inpatient hospital benefits, post hospital care in skilled nursing facilities, home health care in the patient’s home, or hospice care for terminally ill patients.

**Medicare Part B** is the medical insurance part of the program which provides coverage for medical services and supplies furnished by physicians or others in connection with physician services, outpatient hospital care, outpatient physician therapy services, and home health care.

**Medicare Part C** allows the Centers for Medicare and Medicaid Services (CMS) to contract with Medicare Advantage Plans, like LMCHP. Plans must cover all Medicare Part A and Part B health care benefits. Some managed care plans cover extras, like prescription drugs and fitness programs. Everyone who has Medicare Parts A and B is eligible, except those who have end stage renal disease.

**Medicare Part D** is the prescription drug coverage that provides members with a prescription drug benefit and may be part of the Medicare Advantage Plan benefits. This benefit became available to Medicare recipients effective January 1, 2006.

Leon Medical Centers Health Plans is an HMO plan with a Medicare contract. Enrollment in Leon Medical Centers Health Plans depends on contract renewal.

- LMCHP is a Medicare replacement plan that contracted with CMS (Centers for Medicare and Medicaid Services) in June, 2005. LMCHP is a Cigna-HealthSpring Company.

### ADDITIONAL LMCHP BENEFITS

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<thead>
<tr>
<th>Benefit</th>
<th>LMCHP</th>
<th>Original Medicare</th>
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<tbody>
<tr>
<td>Routine Transportation</td>
<td>Covered</td>
<td>Not Offered</td>
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<tr>
<td>Routine Vision Exam</td>
<td>Covered</td>
<td>Not Offered</td>
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<tr>
<td>Routine Hearing Exam</td>
<td>Covered</td>
<td>Not Offered</td>
</tr>
<tr>
<td>Routine Physical Exam</td>
<td>Covered</td>
<td>Not Offered</td>
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<tr>
<td>Dental</td>
<td>Covered</td>
<td>Not Offered</td>
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<tr>
<td>Vitamins</td>
<td>Covered</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>
The geographic service area for our Plan.
The zip codes in Miami-Dade County in our service area are listed below:
33010, 33012, 33013, 33014, 33015, 33016, 33018, 33054, 33055,
33056, 33125, 33126, 33127, 33128, 33129, 33130, 33131, 33132,
33133, 33134, 33135, 33136, 33137, 33138, 33139, 33140, 33141,
33142, 33143, 33144, 33145, 33146, 33147, 33150, 33155, 33156,
33157, 33158, 33161, 33165, 33166, 33167, 33168, 33169, 33170,
33172, 33173, 33174, 33175, 33176, 33177, 33178, 33182, 33183,
33184, 33185, 33186, 33187, 33189, 33190, 33192, 33193, 33194,
33196
# Table of Contents

I. Telephone Numbers and Addresses.................................................................1-3
II. Member ID Card and Eligibility.................................................................4-5
III. Primary Care Physician (PCP) Responsibilities........................................6-15
IV. Specialty Care Physician (SCP) Responsibilities................................16-25
V. Office Administration..................................................................................26-27
VI. Medical Records Guidelines.................................................................28-32
VII. Member Access to Care..........................................................................33-34
VIII. Rights and Responsibilities (Member and Provider)...............................35-38
IX. Claims...........................................................................................................39-41
X. EDI & HIPAA..............................................................................................42-44
XI. Credentialing..............................................................................................45-48
XII. Advance Directives...................................................................................49
XIII. Quality Improvement Program...............................................................50-55
XIV. Utilization Management Program..........................................................56-58
XV. Referrals and Authorizations.................................................................59-66
XVI. Risk Management...................................................................................67-69
XVII. Provider Appeals....................................................................................70
XVIII. Plan Benefits..........................................................................................71-80
XIX. Forms.........................................................................................................81
    a. Medical Records Release...............................................................82
    b. Claims Inquiry Request..............................................................83
    c. Provider Appeal Request..........................................................84
    d. Grievance/Complaint Form.........................................................85-86
    e. Advance Directives.........................................................................87-97
    f. Referral/Pre-Authorization..........................................................98-99
    g. Incident Report.................................................................................100-103
XX. Additional Medicare Advantage Terms and Conditions of Participation and Accreditation Requirements.................................................................104-112
### SECTION I: KEY CONTACTS & PHONE NUMBERS

| **Chief Medical Officer/Medical Director** | 8600 NW 41st Street, Suite 201  
Doral, FL 33166  
(305) 631-4459  
(305) 229-7467 Fax |
|------------------------------------------|---------------------------------------------------------------|
| **Member Services**                      | 8600 NW 41st Street, Suite 201  
Doral, FL 33166  
(305) 559-5366  
711 TTY  
1-866-393-5366  
(305) 642-1144 Fax |
| **Utilization Management (Non-Behavioral)** | 8600 NW 41st Street, Suite 201  
Doral, FL 33166  
(305) 631-5345  
(305) 642-1142 Fax |
| **Quality Assurance and Risk Management** | 8600 NW 41st Street, Suite 201  
Doral, FL 33166  
(305) 646-3736  
(305) 229-7467 Fax |
| **Claims / Claims Appeals (Non-Behavioral)** | P.O. Box 66-9441  
Miami, Fl 33166  
(305) 631-5343  
(305) 642-1156 Fax |
| **Claims Appeals**                        | P.O. Box 66-9440  
Miami, Fl 33166  
(305) 631-5348  
(305) 229-7500 Fax |
<table>
<thead>
<tr>
<th><strong>Provider Relations</strong></th>
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<tr>
<td><strong>Provider Relations</strong></td>
<td>For provider questions or contract issues</td>
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|                        | 8600 NW 41st Street, Suite 201  
Doral, FL 33166  
(305) 646-3776 or  
(305) 631-5242  
(305) 646-3781 Fax |

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<tr>
<th><strong>Other</strong></th>
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<tr>
<td><strong>Pharmacy</strong></td>
<td>For member prescriptions</td>
</tr>
<tr>
<td></td>
<td>(305) 559-5366</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>For member transportation</td>
</tr>
<tr>
<td></td>
<td>(305) 642-5366</td>
</tr>
<tr>
<td><strong>Lab</strong></td>
<td>The University of Miami Department of Pathology is the contracted laboratory for Leon Medical Centers Health Plans, Inc.</td>
</tr>
<tr>
<td></td>
<td>(305) 243-7284</td>
</tr>
<tr>
<td><strong>Home Health Agency</strong></td>
<td>One Homecare Solutions, LLC.</td>
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|                        | 1-855-441-6900  
1-855-441-6941 Fax |
| **DME** | One Home Medical Equipment, LLC. |
|            | 1-855-441-6900  
1-855-441-6941 Fax |
| **Behavioral Health** | Psych Care, Inc.  
Mental Health / Substance Abuse |
|              | 1-800-221-5487  
24 hour helpline |
| **Provider Website (HealthWeb)** | On-line eligibility and benefits information |
|                     | (305) 646-3776 or (305) 631-5242  
www.lmcportal.lmchealthplans.com |
| **EDI Department** | For any electronic claim submission questions |
|                     | (305) 631-4428                  |

<table>
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<tr>
<th><strong>Patient Service Locations</strong></th>
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| **Leon Medical Centers – Bird Road** | 11501 S.W. 40th Street  
Miami, FL 33165  
(305) 642-5366 |
| **Leon Medical Centers – Westchester** | 8888 Coral Way  
Miami, FL 33165  
(305) 642-5366 |
| **Leon Medical Centers – Miami** | 101 S.W. 27th Avenue  
Miami, FL 33135  
(305) 642-5366 |
| **Leon Medical Centers – East Hialeah** | 445 E. 25th Street  
Hialeah, Fl 33013  
(305) 642-5366 |
| **Leon Medical Centers – West Hialeah** | 2020 W. 64th Street  
Hialeah, Fl 33016  
(305) 642-5366 |
<table>
<thead>
<tr>
<th>Medical Center</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leon Medical Centers – Kendall</td>
<td>12515 S.W. 88th Street, Miami, Fl 33183</td>
<td>(305) 642-5366</td>
</tr>
<tr>
<td>Leon Medical Centers – Flagler</td>
<td>7950 NW 2nd Street, Miami, Fl 33126</td>
<td>(305) 642-5366</td>
</tr>
<tr>
<td>Mas Medical Group</td>
<td>3181 Coral Way, 5th Floor, Miami, FL 33145</td>
<td>(305) 858-3494</td>
</tr>
<tr>
<td>Pizarro Medical Group</td>
<td>4795 W. Flagler Street, Miami, FL 33134</td>
<td>(305) 443-6666</td>
</tr>
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Verify all Leon Medical Centers Health Plans members before any services are rendered. You can verify eligibility by:

- Calling Member Services at:
  
  ☏ (305) 559-5366 or toll free at (866) 393-5366

You may call Leon Medical Centers Health Plans Member Service 24 hours a day, 7 days a week. With the member’s ID number you may obtain the following member eligibility information:

- Enrollment status
- PCP name and number
- Office Visit co-pay (if applicable)
- Inpatient co-pay (if applicable)
- Prescription drug co-pay (if applicable)

☐ You may also verify Member Eligibility on-line using HealthWeb. To register for HealthWeb on-line capabilities, you may call:

  ☏ (305) 646-3776 or (305) 631-5242
MEMBER IDENTIFICATION CARD

Below is a sample of Leon Medical Centers Health Plans Member ID Card and the information included:

![ID Card Sample]

**Front**

**This Card Does Not Guarantee Coverage Or Payment Services Must Be Authorized By the Primary Care Physician**

**Medical Providers**
- Auth/Referral: 305-559-5366
- Toll Free: 1-866-393-5366
- TTY#: 711
- Paper Claims: LMC Health Plans
  - P.O. Box 68-9441
  - Miami, FL 33166

**Pharmacy Providers**
- Technical Services: 1-888-625-5086
- Paper Claims:
  - LMC Health Plans Part D Department
  - 8600 NW 41 Street
  - Suite 201
  - Doral, FL 33166

**Members:**
- Member Services: 305-559-5366 or Toll Free 1-866-393-5366
- TTY 711 or www.fmchealthplans.com
- All Reimbursement Request:
  - LMC Health Plans Member Services Department
  - 8600 NW 41 Street, Suite 201 Doral, FL 33166

**Back**
Primary Care Physician (PCP) Selection
Each Member who joins Leon Medical Centers Health Plans selects a Primary Care Physician, who serves as the Member’s personal physician and is responsible for coordinating all aspects of that Member’s medical care within the scope of his/her practice. Referrals may be made to participating specialists, hospitals and ancillary services, when the required services are beyond the scope of the Primary Care Physician’s practice.

As a PCP you accept responsibility for:
- Providing coverage twenty-four (24) hours a day, seven days a week.
- The total management of a member, in and out of the hospital, nursing home, or other institution. The PCP is an extension or jointly manages care with hospitalists.
- Providing or arranging for covered services to plan members.
- Accepting assigned members without discrimination or any screening of such members based on health status.
- Providing appropriate preventive measures, including but, not limited to, routine physical examinations, immunizations, hypertension screening, and PAP smears.
- Arranging for appropriate referrals to participating specialty care physicians for services not normally provided within the PCP’s scope of training and credentials.
- Arranging for appropriate documentation to participating specialty care physicians in order that they can provide the PCP with:
  a. An immediate initial response to the problems presented by the PCP and
  b. A complete final evaluation report with the patient findings to be sent after the initial report, but not later than 2 weeks.
- Arranging for an adequate and speedy system to obtain an authorization number for the referral to take place in the category that was placed:
  a. Routine
  b. Same Day
  c. Emergency
- Maintaining medical records relating to plan members in such a form as required by law and accepted medical practice and provide such records as needed for compliance with state and federal laws and regulation, protect patient confidentiality and participate and cooperate with reasonable reviews, utilization management, and continuing education programs as requested by Leon Medical Centers Health Plans.
- Adhering to Florida Statutes and CMS requirements.
- Cooperating with Leon Medical Centers Health Plans Utilization Management, Quality Improvement and Member policies and procedures.
- Collecting applicable co-payment only, if applicable, and accepting Leon Medical Centers Health Plans reimbursement as a payment in full.
- Not billing the member for services other than non-covered services and co-payments. In the event that Provider shall provide any Member non-Covered Services, Provider shall, prior to the provision of such non-Covered Services, inform the Member in writing (1) of the service(s) to be provided, specifying the changes to be billed to the Member, (2) that
Plan will not pay for or be liable for said services, and (3) that the Member will be financially liable for such services as applicable by law.

It is essential that all referrals be made to participating hospitals and physicians.
STANDARDS OF CONDUCT

POLICY:

Leon Medical Centers Health Plans has a strong commitment to comply with all applicable statutory, regulatory, and other Part D program requirements. Leon Medical Centers Health Plans requires a commitment throughout the organization to carry out daily business activities in a competent and ethical manner. The Board of Directors has developed Standards of Conduct to assist all employees and subcontractors in understanding the organization’s standards and policies.

The Standards of Conduct has been approved by the Board of Directors and applies to all employees and subcontractors. All employees and subcontractors are held to the same standard, and all employees and subcontractors have the same obligation: to adhere to the Standards of Conduct at all times. Any employee or subcontractor found to be in breach of the Standards of Conduct is subject to discipline, up to and including termination.

PURPOSE:

Each employee and subcontractor has a responsibility to Leon Medical Centers Health Plans to be loyal to the organization, its by-laws and ethical principles above private gain.

Each employee and subcontractor must ensure that every employee/subcontractor can have complete confidence in the integrity of the governance of the organization, each employee/subcontractor will respect and adhere to the principles of ethical conduct set forth in the Plan Compliance Program.

STANDARDS OF CONDUCT:

The following general standards apply to every employee and subcontractor. Where a situation is not covered by the standards set forth in the Compliance Program policies, employees and subcontractors will apply the principles described in this document in determining whether their conduct is proper.

Conflict of Interest
You must avoid any situation where a conflict of interest exists or might appear to exist between your personal interests and those of Leon Medical Centers Health Plans. The appearance of conflict of interest may be as serious as an actual conflict of interest. Do not let any outside financial interest influence your decisions or actions taken at. An example might include personal or family enterprises that conduct business with Leon Medical Centers Health Plans, its parent company, or subsidiary or compete with it.

Employees and subcontractors will not engage in financial transactions using organizational information or allow the improper use of such information to further any personnel interest.
There are many types of situations where potential conflicts may arise. If you encounter a situation where a possible conflict of interest may be involved, disclose it promptly to the Leon Medical Centers Health Plans Compliance Officer (305-631-5937).

Compliance with the Law
Leon Medical Centers Health Plans is committed to conducting its activities in accordance with all applicable laws and regulations. These bind all employees and subcontractors.

Business Dealings Between Leon Medical Centers Health Plans and Employees/Subcontractors
Leon Medical Centers Health Plans will not purchase goods or services from any business in which an employee or subcontractor or close relative of an employee/subcontractor has a substantial interest. Similarly, Leon Medical Centers Health Plans will not sell, give or lend any Leon Medical Centers Health Plans, Inc. equipment, furniture, supplies or materials to any employees/subcontractors for their personal use. Occasional exceptions may be made when it’s in the best interest of Leon Medical Centers Health Plans, but only when documented and approved by senior management and the Leon Medical Centers Health Plans Compliance Officer.

Proper Accounting of Books and Records
We expect all employees/subcontractors to record and report all information fully, accurately, completely, honestly and comply with applicable legal requirements. Examples include, but are not limited to, the following: accounting books or records, financial, operational or performance reports, business and time records, expense reports, vouchers, bills, payroll, and claims payments. Financial records must comply with the generally accepted accounting principles. No relevant information is to be omitted or concealed, nor may secret or unrecorded funds or assets or records be created for any purpose.

Record Retention
Disposal or destruction of Leon Medical Centers Health Plans records is not discretionary. The retention of records will be in accordance with legal and regulatory requirements and Leon Medical Centers Health Plans policy. As required by CMS 4069—subpart K, the MAO must retain records for 10 years from the latest contracting period or audit. Records pertaining to litigation or a government investigation or audit will not be destroyed. Records that are subject to audit or current/threatened litigation may not be destroyed unless there is written notification of expiration of the litigation and record destruction is approved by Senior Management and the Compliance Officer.

Records will be maintained in appropriate format, (paper, microfilmed, microfiche, electronic, and imaged) and available within a reasonable timeframe. The Compliance Officer will oversee destruction of any records, which will comply with written procedures.

Confidentiality and Protecting Information
Most information regarding Leon Medical Centers Health Plans business activities is considered confidential and proprietary to Leon Medical Centers Health Plans, and requires the highest
standards of confidentiality. Examples of confidential and proprietary information include, but is not limited to, strategic planning documents, sales, information technology systems and data, reports, customer lists, policyholder health information, broker lists, Leon Medical Centers Health Plans issued materials or supplies and employee/subcontractor information. Also included in Leon Medical Centers Health Plans confidential and proprietary information are Leon Medical Centers Health Plans trade secrets, which is information used by Leon Medical Centers Health Plans, which is not generally known to the public and therefore gives Leon Medical Centers Health Plans an advantage over its competitors.

In addition, since Leon Medical Centers Health Plans is a health insurer, our employees/subcontractors and agents are entrusted with other important confidential and privileged information that may not be released without proper authorization. This includes but is not limited to medical and claims information about subscribers, beneficiaries and health service providers. Therefore, as a Leon Medical Centers Health Plans employee/subcontractor or agent, it is your obligation and duty to maintain the confidentiality of this information while employed or affiliated at Leon Medical Centers Health Plans.

All employees/subcontractors and agents will comply with Health Insurance Portability and Accountability Act (HIPAA) legal requirements regarding the disclosure of Protected Health Information (PHI). The Leon Medical Centers Health Plans policies regarding health care information that is protected by this law will be adhered to by all Leon Medical Centers Health Plans employees/subcontractors, agents and business associates. The policies conform to Federal and State laws and are designed to safeguard patient privacy.

If you leave the employment or terminate your contract with Leon Medical Centers Health Plans, you may not take the originals or copies of any confidential and proprietary information and you may not use this information for your own gain, or that of another person or organization.

**Information Security**
Leon Medical Centers Health Plans employees/subcontractors and agents are responsible for properly using information stored and produced by all Leon Medical Centers Health Plans information systems. All employees/subcontractors and agents will comply with Leon Medical Centers Health Plans’ HIPAA policies that reflect the legal requirements for protecting electronically submitted Protected Health Information.

System users are responsible for preventing unauthorized access to the systems. Passwords and other security codes should not be shared. Accessing your own system’s records for any reason, adjusting your own policy file or claims, or those of other employees/subcontractors or agents without proper authority, is a violation of Leon Medical Centers Health Plans’ Compliance Program, and an offense that may subject an offending employee/subcontractor or agent to discipline, including termination.

Microcomputers, personal computers, Internet access, E-mail or other communication systems are intended for business-related purposes only and not for use that may be considered disruptive, offensive, harassing or harmful to others.
Each software package, unless specifically licensed for Local Area Network (LAN) or site-licensed, may only be used on a single personal computer or microcomputer. Unless expressly permitted by the software license agreement, software cannot be copied for use on more than one Leon Medical Centers Health Plans personal computer or microcomputer.

**Fraud and Abuse**
All employees/subcontractors and agents are responsible to report any suspected health care fraud to the Compliance Officer immediately. Be prepared to provide the physician/provider’s name, phone number and office location, the item or service in question, the date of the service, and reason you believe the claim should not have been paid. Leon Medical Centers Health Plans will protect your identity as much as reasonably possible. Employees/subcontractors and agents must report potential fraud and abuse such as reporting of pricing and rebate fraud/abuse and/or fraudulent sales and marketing practices to CMS and the OIG.

**Dealing with Suppliers and Members**
Conducting business with suppliers and customers can pose ethical problems. As with other areas in these guidelines, the following is intended to assist in making appropriate, responsible and correct decisions. Employees/subcontractors and agents are expected to exercise good judgment and discretion in these matters. Employees/subcontractors will not knowingly make unauthorized commitments or promises of any kind purporting to bind Leon Medical Centers Health Plans. Employees/subcontractors will act impartially and not give preferential treatment to any private organization or individual.

**Kickbacks**
The purchase of sale of goods and services must not lead to employees/subcontractors or their families receiving kickbacks. Kickbacks or rebates may take many forms and are not limited to direct cash payments or credits. If an employee/subcontractor, agent or a policyholder of the family stands to gain personally through a transaction, it is prohibited.

Employees/subcontractors are prohibited from receiving any payment or receipt of payments that can be considered ‘kickbacks’ for the use or recommendation of supplies, services, goods, facilities, or items. This includes knowingly or willfully offering, paying, asking, or receiving money or other benefits, directly or indirectly, in return for favorable terms or treatment.

**Gifts or Gratuities**
Leon Medical Centers Health Plans employees/subcontractors and agents may not accept or encourage gifts of money under any circumstances, nor may they solicit non-monetary gifts, gratuities or any other personal benefit or favor of any kind from suppliers or customers. Employees/subcontractors, agents and their immediate families may accept nominal, unsolicited, non-monetary gifts from business firm or individual doing or seeking to do business with Leon Medical Centers Health Plans. Such gifts may include those that a vendor provides to a wide
spectrum of existing and potential customers, if of a nominal value. Leon Medical Centers Health Plans employees/subcontractors or agents should contact their supervisor or the Compliance Officer if they are unsure if accepting a gift or gratuity is permitted.

Federal Law makes it a crime to give, offer or promise anything of value to any public official for or because of any official act performed or to be performed by such official. It is also a Federal crime to make any payments to public employees, made on account of or as compensation for public duties.

Leon Medical Centers Health Plans employees/subcontractors and agents will not give gifts or gratuities exceeding the value of $10 per gift or $50 per calendar year in the aggregate. Leon Medical Centers Health Plans employees/subcontractors or agents will contact their supervisor or the Compliance Officer if they are unsure if giving a gift or gratuity is acceptable.

Employees/subcontractors are prohibited the receipt of payments, discounts, or gifts that may be considered ‘remuneration’ for referral of patients. The payment of or receipt of such ‘remuneration’ is barred by law for the purchase, lease, ordering, or recommending any goods, facilities, services, or items.

Leon Medical Centers Health Plans employees/subcontractors and agents are prohibited from giving any government employee or representative any gifts or gratuities.

Entertainment

From time to time, employees/subcontractors may offer or accept entertainment, as long as it is not excessive, provided it occurs infrequently and it does not involve lavish expenditures. Offering or accepting entertainment that is not a reasonable addition to a business relationship but is primarily intended to gain favor or influence must be avoided.

Employees/subcontractors business dealings may include a shared meal or similar social occasions, which may be proper business expense or activities. More extensive entertainment will only rarely be consistent with Leon Medical Centers Health Plans policy and should be reviewed and approved by the Compliance Officer and/or legal counsel.

Payments to Agents and Consultants

Agreements with agents or consultants must be in writing. Such agreements must clearly and accurately set forth the services to be performed, the basis for earning the commission or fee involved and the applicable rate or fee. Any such payment must be reasonable in amount, not excessive in terms of industry practices, not exceed any applicable statutory or regulatory maximums, and be commensurate with the value of the services rendered.

Other Improper Payments or Actions

The use of Leon Medical Centers Health Plans funds or assets for any unlawful or unethical purpose is prohibited. Any improper payment made by a Leon Medical Centers Health Plans employee/subcontractor is likewise improper when made by a commission agent, consultant or
other third party on behalf of Leon Medical Centers Health Plans. This is also true for an
employee/subcontractor or agent who knows or has reason to know that a payment will be made.
The making of any payment to a third party for any purpose other than that disclosed on the
payment documentation is also prohibited.

Property owned by Leon Medical Centers Health Plans should be used for business purposes
only, and should not be used for personal benefit. This includes owned, rented, or leased
property, equipment, vehicles, supplies, computer systems or software, office supplies, facilities,
services, or any other forms of property. The assets of individuals or companies with which we
do business, while in our care or use, should be treated with the same respect as property owned
by Leon Medical Centers Health Plans.

**Federal Contracts and Federal Procurement**
Leon Medical Centers Health Plans is subject to the Federal Procurement Integrity Act when
bidding on Federal contracts. This law prohibits certain business conduct for companies seeking
to obtain work from the Federal Government. During the bidding process, Leon Medical Centers
Health Plans employees/subcontractors and agents may not:

- Offer or discuss employment or business opportunities at Leon Medical Centers Health
  Plans with agency procurement officials.
- Offer or give gratuities or anything of value to any agency procurement official
- Seek or obtain any confidential information about the selection criteria before the
  contract is awarded.

In addition, other Federal provisions prohibit Federal officials from accepting anything of value,
subject to reasonable exceptions such as modest items of food and refreshments. Because of
these restrictions, no employee/subcontractor or agent shall either offer or make a gift to a
federal employee.

**Political Activities and Contributions**
Federal laws restrict the use of corporate funds in connection with Federal elections. Similarly,
state laws restrict the use of such funds in connection with state and local elections.
Accordingly, it is against Leon Medical Centers Health Plans policy (and also may be illegal) for
employees/subcontractors and agents to include, directly or indirectly, any political contribution
on expense accounts or in any way that causes Leon Medical Centers Health Plans to reimburse
them for that expense.

The political process has become highly regulated, and anyone who has a question about what is
or is not an acceptable contribution should consult with the Leon Medical Centers Health Plans
Compliance Officer.

**Insider Trading**
If any Leon Medical Centers Health Plans employee/subcontractor or agent becomes aware of
non-public information about Leon Medical Centers Health Plans, or another related company,
as a result of their affiliation with Leon Medical Centers Health Plans, they may not disclose this
information to anyone. As an employee/subcontractor or agent of Leon Medical Centers Health Plans you are prohibited from buyer or selling securities based on this information. This also includes using insider trading to make investment decision in Leon Medical Centers Health Plans’ competitors.

If you have any questions regarding adhering to trading laws, or are aware of others who may be in violation, notify the Leon Medical Centers Health Plans Compliance Officer immediately (305-631-5937).

**Employment Relationship**

Leon Medical Centers Health Plans believes that each employee/subcontractor and agent should be able to work in a professional atmosphere without fear of retribution. To that end, Leon Medical Centers Health Plans is committed to complying with all the laws and regulations affecting safety, health and the environment.

In addition, Leon Medical Centers Health Plans is committed to providing a work environment that is free of harassment and discrimination in all aspects of the contractual relationship, including recruitment and contracting, work assignment, transfer, compensation administration, selection for training, corrective action and termination.

All employees/subcontractors and agents are required to observe our commitment and extend to each other appropriate behavior in the workplace. All employees/subcontractors should be familiar with Leon Medical Centers Health Plans’ policies and procedures.

**Seeking Guidance and Reporting Violations**

All employees/subcontractors must report any actual or suspected violation of this Compliance Program by completing an incident form or speaking to your supervisor. Employees/subcontractors will disclose waste, fraud, abuse, and corruption to the Compliance Officer or appropriate authorities. You may also report the matter to the Leon Medical Centers Health Plans Compliance Officer.

Reports may also be filed anonymously by calling 305-631-5937. The person to whom the incident is reported may refer it to others for assistance or action.

Steps will be taken to protect anonymity and confidentiality where warranted and appropriate. Leon Medical Centers Health Plans will not tolerate any form of retaliation against a person for reporting an issue in accordance with this document.

**Corrective Action and/or Discipline**

Individuals who violate any of Leon Medical Centers Health Plans’ Compliance Program requirements or violate related corporate policies and procedures, or anyone who knowingly fails to report violations, or any supervisor, officer or agent, who fails to oversee compliance by those he or she supervises, is subject to disciplinary action.

 Discipline ranges from warning to termination. Violations may also result in criminal referral and reports to law enforcement and government agencies.
Any individual who harasses or threatens an employee/subcontractor for reporting violations will be terminated.

**Claims and Referrals**
Employees/subcontractors dealing with claims payment are expected to maintain the highest standard of integrity, honesty, and diligence in the performance of these important duties. Leon Medical Centers Health Plans is committed to attempting to achieve full accuracy in our financial dealings. False, inaccurate, or questionable claims payment, coding should be reported immediately to the Compliance Officer.

Examples that may be considered fraudulent or abusive include:

- a) Claims reimbursement for services that were not rendered
- b) Paying duplicate claims for the same services
- c) Paying for services not medically necessary

The Plan is in the business of providing the delivery of appropriate health care services. Patients served by our organization may be referred to contracted providers as is medically necessary to the treatment of their condition. The choice of providers should be made by the patient, with guidance from his or her PCP as to which providers are qualified and medically appropriate. Referrals to or from the Plan by providers who have a financial relationship with the Plan may only be made if specific provisions of law (the Stark Act and Safe Harbor Provisions) are met. Any referral or patterns of referral that is questionable should be brought to the attention of the Compliance Officer, who is obligated to review that action with the advice of legal counsel.

It is the responsibility of each employee/subcontractor to attempt to recognize fraudulent or abusive occurrences or situations and to report them promptly to their supervisors, the Compliance Officer/contact, the Compliance Hotline, or other resources as necessary.

Retaliation or retribution of any kind on the part of medical staff members, managers, co-workers, or employees/subcontractors against those reporting fraudulent or abusive activity or the possibility of fraudulent or abusive activity will not be tolerated. Employees/subcontractors who feel they are the target of retaliation or retribution should report immediately to their supervisor; and/or contact the Compliance Officer/contact, and may be other specific rights as well.

SECTION IV: ROLE OF THE SPECIALIST PHYSICIAN

Specialist Care Physician (SCP) Responsibilities
As a Participating Specialist, you are responsible for accepting for treatment, only those Members who have been referred by a Leon Medical Centers Health Plans, Inc. Primary Care Physician. Participating Specialists are contracted to work closely with our referring PCPs to enhance the quality and continuity of care provided to our Members. Only Participating Specialist services which have been referred in advance to the Primary Care Physician will be paid by Leon Medical Centers Health Plans. The PCP generated referral should include a specified number of visits and time frame for treatment. A Participating Specialist may not perform services beyond the scope of the PCP’s referral. Services performed beyond the scope of the PCP’s referral are subject to payment denial by Leon Medical Centers Health Plans.

As a Leon Medical Centers Health Plans Participating Specialist, you accept responsibility for:

- Providing covered specialty care services working in collaboration with the PCP.
- Providing coverage twenty-four (24) hours a day, seven (7) days a week.
- Providing covered services to plan members only upon receiving the appropriate referral authorization from a Leon Medical Centers Health Plans Primary Care Physician or the Utilization Management Department.
- Informing the PCP of the member’s care, including but not limited to, informing the PCP of any testing, hospitalizations, or other care that is ordered.
- Obtaining any required authorization or referrals.
- Maintaining active and unrestricted admitting privileges at one or more participating hospitals.
- Adhering to all applicable Florida Statutes and CMS requirements.
- Cooperating with Leon Medical Centers Health Plans Credential, Utilization Management, Quality Improvement and Member policies and procedures.
- Collecting applicable co-payment and/or deductibles only, if applicable, and accept Leon Medical Centers Health Plans reimbursement as payment in full.
- Nor billing the member for services other than non-covered services and co-payments, if applicable. In the event that Provider shall provide any Member non-Covered Services, Provider shall, prior to the provision of such non-Covered Services, inform the Member in writing (1) of the service(s) to be provided, specifying the changes to be billed to the Member, (2) that Plan will not pay for or be liable for said services, and (3) that the Member will be financially liable for such services as applicable by law.

Claims Submission (Refer to the Claim Section for more details)
- Timely Filing Policy: Claims must be filed within 90 days or in accordance with the terms of your current contract.
- Claims must be submitted on the standard HCFA 1500 Claim Form.
- Electronic Filing is available: Contact Provider Relations for additional information.
- To extend an existing referral, call the Primary Care Physician with an updated treatment plan.
STANDARDS OF CONDUCT

POLICY:

Leon Medical Centers Health Plans has a strong commitment to comply with all applicable statutory, regulatory, and other Part D program requirements. Leon Medical Centers Health Plans requires a commitment throughout the organization to carry out daily business activities in a competent and ethical manner. The Board of Directors has developed Standards of Conduct to assist all employees and subcontractors in understanding the organization’s standards and policies.

The Standards of Conduct has been approved by the Board of Directors and applies to all employees and subcontractors. All employees and subcontractors are held to the same standard, and all employees and subcontractors have the same obligation: to adhere to the Standards of Conduct at all times. Any employee or subcontractor found to be in breach of the Standards of Conduct is subject to discipline, up to and including termination.

PURPOSE:

Each employee and subcontractor has a responsibility to Leon Medical Centers Health Plans to be loyal to the organization, its by-laws and ethical principles above private gain.

Each employee and subcontractor must ensure that every employee/subcontractor can have complete confidence in the integrity of the governance of the organization, each employee/subcontractor will respect and adhere to the principles of ethical conduct set forth in the Plan Compliance Program.

STANDARDS OF CONDUCT:

The following general standards apply to every employee and subcontractor. Where a situation is not covered by the standards set forth in the Compliance Program policies, employees and subcontractors will apply the principles described in this document in determining whether their conduct is proper.

Conflict of Interest

You must avoid any situation where a conflict of interest exists or might appear to exist between your personal interests and those of Leon Medical Centers Health Plans. The appearance of conflict of interest may be as serious as an actual conflict of interest. Do not let any outside financial interest influence your decisions or actions taken at. An example might include personal or family enterprises that conduct business with Leon Medical Centers Health Plans, its parent company, or subsidiary or compete with it.
Employees and subcontractors will not engage in financial transactions using organizational information or allow the improper use of such information to further any personnel interest.

There are many types of situations where potential conflicts may arise. If you encounter a situation where a possible conflict of interest may be involved, disclose it promptly to the Leon Medical Centers Health Plans Compliance Officer (305-631-5937).

**Compliance with the Law**
Leon Medical Centers Health Plans is committed to conducting its activities in accordance with all applicable laws and regulations. These bind all employees and subcontractors.

**Business Dealings Between Leon Medical Centers Health Plans and Employees/Subcontractors**
Leon Medical Centers Health Plans will not purchase goods or services from any business in which an employee or subcontractor or close relative of an employee/subcontractor has a substantial interest. Similarly, Leon Medical Centers Health Plans will not sell, give or lend any Leon Medical Centers Health Plans, Inc. equipment, furniture, supplies or materials to any employees/subcontractors for their personal use. Occasional exceptions may be made when it’s in the best interest of Leon Medical Centers Health Plans, but only when documented and approved by senior management and the Leon Medical Centers Health Plans Compliance Officer.

**Proper Accounting of Books and Records**
We expect all employees/subcontractors to record and report all information fully, accurately, completely, honestly and comply with applicable legal requirements. Examples include, but are not limited to, the following: accounting books or records, financial, operational or performance reports, business and time records, expense reports, vouchers, bills, payroll, and claims payments. Financial records must comply with the generally accepted accounting principles. No relevant information is to be omitted or concealed, nor may secret or unrecorded funds or assets or records be created for any purpose.

**Record Retention**
Disposal or destruction of Leon Medical Centers Health Plans records is not discretionary. The retention of records will be in accordance with legal and regulatory requirements and Leon Medical Centers Health Plans policy. As required by CMS 4069—subpart K, the MAO must retain records for 10 years from the latest contracting period or audit. Records pertaining to litigation or a government investigation or audit will not be destroyed. Records that are subject to audit or current/threatened litigation may not be destroyed unless there is written notification of expiration of the litigation and record destruction is approved by Senior Management and the Compliance Officer.

Records will be maintained in appropriate format, (paper, microfilmed, microfiche, electronic, and imaged) and available within a reasonable timeframe. The Compliance Officer will oversee destruction of any records, which will comply with written procedures.
Confidentiality and Protecting Information

Most information regarding Leon Medical Centers Health Plans business activities is considered confidential and proprietary to Leon Medical Centers Health Plans, and requires the highest standards of confidentiality. Examples of confidential and proprietary information include, but is not limited to, strategic planning documents, sales, information technology systems and data, reports, customer lists, policyholder health information, broker lists, Leon Medical Centers Health Plans issued materials or supplies and employee/subcontractor information. Also included in Leon Medical Centers Health Plans confidential and proprietary information are Leon Medical Centers Health Plans trade secrets, which is information used by Leon Medical Centers Health Plans, which is not generally known to the public and therefore gives Leon Medical Centers Health Plans an advantage over its competitors.

In addition, since Leon Medical Centers Health Plans is a health insurer, our employees/subcontractors and agents are entrusted with other important confidential and privileged information that may not be released without proper authorization. This includes but is not limited to medical and claims information about subscribers, beneficiaries and health service providers. Therefore, as a Leon Medical Centers Health Plans employee/subcontractor or agent, it is your obligation and duty to maintain the confidentiality of this information while employed or affiliated at Leon Medical Centers Health Plans.

All employees/subcontractors and agents will comply with Health Insurance Portability and Accountability Act (HIPAA) legal requirements regarding the disclosure of Protected Health Information (PHI). The Leon Medical Centers Health Plans policies regarding health care information that is protected by this law will be adhered to by all Leon Medical Centers Health Plans employees/subcontractors, agents and business associates. The policies conform to Federal and State laws and are designed to safeguard patient privacy.

If you leave the employment or terminate your contract with Leon Medical Centers Health Plans, you may not take the originals or copies of any confidential and proprietary information and you may not use this information for your own gain, or that of another person or organization.

Information Security

Leon Medical Centers Health Plans employees/subcontractors and agents are responsible for properly using information stored and produced by all Leon Medical Centers Health Plans information systems. All employees/subcontractors and agents will comply with Leon Medical Centers Health Plans’ HIPAA policies that reflect the legal requirements for protecting electronically submitted Protected Health Information.

System users are responsible for preventing unauthorized access to the systems. Passwords and other security codes should not be shared. Accessing your own system’s records for any reason, adjusting your own policy file or claims, or those of other employees/subcontractors or agents without proper authority, is a violation of Leon Medical Centers Health Plans’ Compliance Program, and an offense that may subject an offending employee/subcontractor or agent to discipline, including termination.
Microcomputers, personal computers, Internet access, E-mail or other communication systems are intended for business-related purposes only and not for use that may be considered disruptive, offensive, harassing or harmful to others.

Each software package, unless specifically licensed for Local Area Network (LAN) or site-licensed, may only be used on a single personal computer or microcomputer. Unless expressly permitted by the software license agreement, software cannot be copied for use on more than one Leon Medical Centers Health Plans personal computer or microcomputer.

**Fraud and Abuse**

All employees/subcontractors and agents are responsible to report any suspected health care fraud to the Compliance Officer immediately. Be prepared to provide the physician/provider’s name, phone number and office location, the item or service in question, the date of the service, and reason you believe the claim should not have been paid. Leon Medical Centers Health Plans will protect your identity as much as reasonably possible. Employees/subcontractors and agents must report potential fraud and abuse such as reporting of pricing and rebate fraud/abuse and/or fraudulent sales and marketing practices to CMS and the OIG.

**Dealing with Suppliers and Members**

Conducting business with suppliers and customers can pose ethical problems. As with other areas in these guidelines, the following is intended to assist in making appropriate, responsible and correct decisions. Employees/subcontractors and agents are expected to exercise good judgment and discretion in these matters. Employees/subcontractors will not knowingly make unauthorized commitments or promises of any kind purporting to bind Leon Medical Centers Health Plans. Employees/subcontractors will act impartially and not give preferential treatment to any private organization or individual.

**Kickbacks**

The purchase of sale of goods and services must not lead to employees/subcontractors or their families receiving kickbacks. Kickbacks or rebates may take many forms and are not limited to direct cash payments or credits. If an employee/subcontractor, agent or a policyholder of the family stands to gain personally through a transaction, it is prohibited.

Employees/subcontractors are prohibited from receiving any payment or receipt of payments that can be considered ‘kickbacks’ for the use or recommendation of supplies, services, goods, facilities, or items. This includes knowingly or willfully offering, paying, asking, or receiving money or other benefits, directly or indirectly, in return for favorable terms or treatment.
Gifts or Gratuities

Leon Medical Centers Health Plans employees/subcontractors and agents may not accept or encourage gifts of money under any circumstances, nor may they solicit non-monetary gifts, gratuities or any other personal benefit or favor of any kind from suppliers or customers. Employees/subcontractors, agents and their immediate families may accept nominal, unsolicited, non-monetary gifts from business firm or individual doing or seeking to do business with Leon Medical Centers Health Plans. Such gifts may include those that a vendor provides to a wide spectrum of existing and potential customers, if of a nominal value. Leon Medical Centers Health Plans employees/subcontractors or agents should contact their supervisor or the Compliance Officer if they are unsure if accepting a gift or gratuity is permitted.

Federal Law makes it a crime to give, offer or promise anything of value to any public official for or because of any official act performed or to be performed by such official. It is also a Federal crime to make any payments to public employees, made on account of or as compensation for public duties.

Leon Medical Centers Health Plans employees/subcontractors and agents will not give gifts or gratuities exceeding the value of $10 per gift or $50 per calendar year in the aggregate. Leon Medical Centers Health Plans employees/subcontractors or agents will contact their supervisor or the Compliance Officer if they are unsure if giving a gift or gratuity is acceptable.

Employees/subcontractors are prohibited the receipt of payments, discounts, or gifts that may be considered ‘remuneration’ for referral of patients. The payment of or receipt of such ‘remuneration’ is barred by law for the purchase, lease, ordering, or recommending any goods, facilities, services, or items.

Leon Medical Centers Health Plans employees/subcontractors and agents are prohibited from giving any government employee or representative any gifts or gratuities.

Entertainment

From time to time, employees/subcontractors may offer or accept entertainment, as long as it is not excessive, provided it occurs infrequently and it does not involve lavish expenditures. Offering or accepting entertainment that is not a reasonable addition to a business relationship but is primarily intended to gain favor or influence must be avoided.

Employees/subcontractors business dealings may include a shared meal or similar social occasions, which may be proper business expense or activities. More extensive entertainment will only rarely be consistent with Leon Medical Centers Health Plans policy and should be reviewed and approved by the Compliance Officer and/or legal counsel.
Payments to Agents and Consultants

Agreements with agents or consultants must be in writing. Such agreements must clearly and accurately set forth the services to be performed, the basis for earning the commission or fee involved and the applicable rate or fee. Any such payment must be reasonable in amount, not excessive in terms of industry practices, not exceed any applicable statutory or regulatory maximums, and be commensurate with the value of the services rendered.

Other Improper Payments or Actions

The use of Leon Medical Centers Health Plans funds or assets for any unlawful or unethical purpose is prohibited. Any improper payment made by a Leon Medical Centers Health Plans employee/subcontractor is likewise improper when made by a commission agent, consultant or other third party on behalf of Leon Medical Centers Health Plans. This is also true for an employee/subcontractor or agent who knows or has reason to know that a payment will be made. The making of any payment to a third party for any purpose other than that disclosed on the payment documentation is also prohibited.

Property owned by Leon Medical Centers Health Plans should be used for business purposes only, and should not be used for personal benefit. This includes owned, rented, or leased property, equipment, vehicles, supplies, computer systems or software, office supplies, facilities, services, or any other forms of property. The assets of individuals or companies with which we do business, while in our care or use, should be treated with the same respect as property owned by Leon Medical Centers Health Plans.

Federal Contracts and Federal Procurement

Leon Medical Centers Health Plans is subject to the Federal Procurement Integrity Act when bidding on Federal contracts. This law prohibits certain business conduct for companies seeking to obtain work from the Federal Government. During the bidding process, Leon Medical Centers Health Plans employees/subcontractors and agents may not:

- Offer or discuss employment or business opportunities at Leon Medical Centers Health Plans with agency procurement officials.
- Offer or give gratuities or anything of value to any agency procurement official
- Seek or obtain any confidential information about the selection criteria before the contract is awarded.

In addition, other Federal provisions prohibit Federal officials from accepting anything of value, subject to reasonable exceptions such as modest items of food and refreshments. Because of these restrictions, no employee/subcontractor or agent shall either offer or make a gift to a federal employee.
**Political Activities and Contributions**
Federal laws restrict the use of corporate funds in connection with Federal elections. Similarly, state laws restrict the use of such funds in connection with state and local elections. Accordingly, it is against Leon Medical Centers Health Plans policy (and also may be illegal) for employees/subcontractors and agents to include, directly or indirectly, any political contribution on expense accounts or in any way that causes Leon Medical Centers Health Plans to reimburse them for that expense.

The political process has become highly regulated, and anyone who has a question about what is or is not an acceptable contribution should consult with the Leon Medical Centers Health Plans Compliance Officer.

**Insider Trading**
If any Leon Medical Centers Health Plans employee/subcontractor or agent becomes aware of non-public information about Leon Medical Centers Health Plans, or another related company, as a result of their affiliation with Leon Medical Centers Health Plans, they may not disclose this information to anyone. As an employee/subcontractor or agent of Leon Medical Centers Health Plans you are prohibited from buyer or selling securities based on this information. This also includes using insider trading to make investment decision in Leon Medical Centers Health Plans’ competitors.

If you have any questions regarding adhering to trading laws, or are aware of others who may be in violation, notify the Leon Medical Centers Health Plans Compliance Officer immediately (305-631-5937).

**Employment Relationship**
Leon Medical Centers Health Plans believes that each employee/subcontractor and agent should be able to work in a professional atmosphere without fear of retribution. To that end, Leon Medical Centers Health Plans is committed to complying with all the laws and regulations affecting safety, health and the environment.

In addition, Leon Medical Centers Health Plans is committed to providing a work environment that is free of harassment and discrimination in all aspects of the contractual relationship, including recruitment and contracting, work assignment, transfer, compensation administration, selection for training, corrective action and termination.

All employees/subcontractors and agents are required to observe our commitment and extend to each other appropriate behavior in the workplace. All employees/subcontractors should be familiar with Leon Medical Centers Health Plans’ policies and procedures.

**Seeking Guidance and Reporting Violations**
All employees/subcontractors must report any actual or suspected violation of this Compliance Program by completing an incident form or speaking to your supervisor. Employees/subcontractors will disclose waste, fraud, abuse, and corruption to the Compliance Officer or appropriate authorities. You may also report the matter to the Leon Medical Centers Health Plans Compliance Officer.
Reports may also be filed anonymously by calling 305-631-5937. The person to whom the incident is reported may refer it to others for assistance or action.

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Discipline ranges from warning to termination. Violations may also result in criminal referral and reports to law enforcement and government agencies.

Any individual who harasses or threatens an employee/subcontractor for reporting violations will be terminated.

**Claims and Referrals**

Employees/subcontractors dealing with claims payment are expected to maintain the highest standard of integrity, honesty, and diligence in the performance of these important duties. Leon Medical Centers Health Plans is committed to attempting to achieve full accuracy in our financial dealings. False, inaccurate, or questionable claims payment, coding should be reported immediately to the Compliance Officer.

Examples that may be considered fraudulent or abusive include:

a) Claims reimbursement for services that were not rendered  
b) Paying duplicate claims for the same services  
c) Down coding to less complex services than were actually performed  
d) Paying for services not medically necessary

The Plan is in the business of providing the delivery of appropriate health care services. Patients served by our organization may be referred to contracted providers as is medically necessary to the treatment of their condition. The choice of providers should be made by the patient, with guidance from his or her PCP as to which providers are qualified and medically appropriate. Referrals to or from the Plan by providers who have a financial relationship with the Plan may only be made if specific provisions of law (the Stark Act and Safe Harbor Provisions) are met. Any referral or patterns of referral that is questionable should be brought to the attention of the Compliance Officer, who is obligated to review that action with the advice of legal counsel.

It is the responsibility of each employee/subcontractor to attempt to recognize fraudulent or abusive occurrences or situations and to report them promptly to their supervisors, the Compliance Officer/contact, the Compliance Hotline, or other resources as necessary.
Retaliation or retribution of any kind on the part of medical staff members, managers, co-workers, or employees/subcontractors against those reporting fraudulent or abusive activity or the possibility of fraudulent or abusive activity will not be tolerated. Employees/subcontractors who feel they are the target of retaliation or retribution should report immediately to their supervisor; and/or contact the Compliance Officer/contact, and may be other specific rights as well.

SECTION V: OFFICE ADMINISTRATION

Changes in Provider Information
Please notify the Leon Medical Centers Health Plans Provider Relations Department in writing of any changes to your business name, address, TIN or if you add or close a location. The documentation must include a W-9. You may also fax the information to (305) 646-3781. By providing this information as quickly as possible, you will ensure that your site is correctly listed in the Provider Directory and your claims will be properly adjudicated. Please note claims are adjudicated based on the location where services were rendered. Claims submitted from locations not on file with Leon Medical Centers Health Plans may be subject to incorrect payment or denial.

Changes in Physician Practice
Any changes in Tax Identification Number, Address and/or Phone Numbers, Partnership Status, Board Certification Status, or other changes affecting the practice must be communicated to Leon Medical Centers Health Plans Provider Relations Department in writing at least thirty (30) days before the change becomes effective. Some changes may require the physician to go through a re-credentialing process.

Provider Groups shall provide LMCHP with, but not limited to, a list of the names, practice locations, federal tax identification numbers, medical practice license numbers, DEA numbers, DPS numbers, Medicare certification numbers, professional practice names and legal partnerships, and the business hours of all providers and allied health professionals that contract with Group Provider in a format acceptable to LMCHP. LMCHP shall notify Group Provider of all such providers and allied health professionals approved by LMCHP to be Group Providers. Group Provider shall provide LMCHP with updated additions, deletions, status changes, and address changes to the list of Group Providers in a format acceptable to LMCHP within thirty (30) days of any such change.

Provider Group shall use best efforts to notify LMCHP in writing at least ninety (90) days prior to any action by Provider Group to terminate a Group Provider’s agreement with Provider Group. When ninety (90) days prior notice is not possible, Provider Group shall provide as much advance notice as possible. Provider Group shall notify LMCHP whenever a Group Provider provides notice that he/she intends to terminate employment with Provider Group and whenever Provider Group knows of an occurrence causing the immediate termination of a Group Provider under of this Agreement.

Submission of the Provider NPI:
Once you obtain your NPI letter from the NPI Enumerator, Leon Medical Centers Health Plans will accept this letter as confirmation of your NPI. The NPI is necessary for proper claims submission.
Confidentiality Statement
All Leon Medical Centers Health Plans providers and their staff are required to maintain the confidentiality of the member’s medical information. Medical records must be stored away where only authorized personnel can obtain access. Medical records cannot be disclosed to unauthorized personnel without written consent of the member.

Discharge of a Member from Physician’s Care
If after reasonable effort, the physician is unable to establish and maintain a satisfactory relationship with a member, the physician may request that the member be discharged from his/her care and transferred to an alternative physician. The physician must submit the request in writing to the Leon Medical Centers Health Plans, Member Service Department. Reasons for a discharge include:

- Disruptive behavior/verbal abuse
- Physical threats/abuse – this warrants immediate action. Please contact Leon Medical Centers Health Plans and notify the proper authorities.

The physician must provide the member with the following before a discharge:

- At least a verbal warning
- At least one written warning

NOTE: The PCP must provide adequate documentation in the member’s medical record of the verbal and/or written warnings. The physician is obligated to provide care up to 30 days after written notification to the member.

Covering Physicians
Leon Medical Centers Health Plans physicians must arrange for coverage of their practice 24 hours a day, 7 days per week. The covering physician must be a Leon Medical Centers Health Plans provider and notification must be sent to Leon Medical Centers Health Plans of covering physician information. If the covering physician is not in your group practice you must notify Leon Medical Centers Health Plans, in writing, to prevent claims payment issues. Payment to a non-health plan provider will be the responsibility of the physician.
Leon Medical Centers Health Plans, Inc. has developed and maintains a system for the collection, processing, maintenance, storage, retrieval, and distribution of patient medical records. Leon Medical Centers Health Plans assures its providers maintain a medical records system that is consistent with professional standards and those of AAAHC, AHCA, and CMS. Leon Medical Centers Health Plans’ guidelines for medical record documentation are distributed to providers through the provider manual, provider newsletter and mailings. Leon Medical Centers Health Plans also provides the guidelines upon request. Leon Medical Centers Health Plans assures its providers maintain a medical record system which:

- An individual medical record is established for each person receiving care.
- Permits prompt retrieval of legible and timely information, accurately documented and readily available to appropriate or authorized health care practitioners. (59A-12005(1), F.A.C.)
- Protects the confidentiality of patient records. Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration destruction, and unauthorized or inadvertent disclosure. (59A-12005(2), F.A.C., s.641.59, F.S.)
- Identifies the patient as follows: (59A-12.005(4), F.A.C.)
  a. Name,
  b. Member identification number,
  c. Date of birth,
  d. Sex, and
  e. Biographical data that includes the address, employer, home and work telephone numbers, legal guardianship and marital status.

Records in the medical record a summary of significant surgical procedures, past and current diagnoses or problems and allergies and untoward reactions to drugs and current medications. (59A-12.005(3), F.A.C.)

Indicate in the medical record for each visit the following information as appropriate: (59A-12.005(5), F.A.C.)

a) Date;
b) Chief complaint or purpose of visit;
c) Objective findings of practitioner;
d) Diagnosis or medical impression;
e) Studies ordered, for example: lab, x-ray, EKG; and referral reports;
f) Therapies administered and prescribed;
g) Name and profession of practitioner rendering services, for example: M.D., D.O., D.C., D.P.M., R.N., O.D., etc., including signature or initials of practitioner;
h) Disposition, recommendations, instructions to the patient and evidence of whether there was follow-up; and
i) Outcome of services.

The medical record includes the documentation of the existence of an advanced directive. A health care practitioner/provider who is provided with the individual’s advanced directive shall make the advanced directive or a copy thereof a part of the individual’s medical record. (59A-12.013(2)(c), F.A.C.)

The practitioner/provider is responsible for requesting consent of members for release of medical records and for obtaining all documents and medical records from contracted providers necessary to carry out the provisions of Chapter 641, Part III, F.S., and Chapter 59A-12, F.A.C. (59A-12.005(6), F.A.C.)

As required by the Accreditation Association for Ambulatory Health Care (AAAHC):
1. The medical record content and format are uniform.
2. The medical record is legible to clinical personnel with or without assistance.
3. Contains the member’s medical history.
4. The diagnostic procedures are appropriate based on diagnosis.
5. The treatment is consistent with the working diagnosis.
6. Consultation and referrals are appropriate and timely.
7. Appropriate follow-up is provided, including evidence of continuity of care, if applicable.
8. Outcome of services is appropriate.
9. Missed and canceled appointments are followed-up appropriately.
10. When indicated, diagnostic summaries are present and used appropriately.
11. Laboratory reports, radiology reports, and other pertinent information are recorded adequately and timely.

Significant advice given by telephone is recorded.

**Authorization for Release of Medical Records**
Medical records of Leon Medical Centers Health Plans must be released upon receipt of a written request signed by the patient or guardian, or the person representative of the deceased member. The request form included in this manual may be used by members requesting release of their medical records to others of their choice, such as other providers, insurance companies, or attorneys. Patients also have the right to receive copies of their own records. Leon Medical Centers Health Plans physicians may not charge any fees to Leon Medical Centers Health Plans member or provider.
### Medical Record Documentation Standards – Adult

The following standards and definitions of indicators correspond to the standards and numbered indicators on the Adult Medical Record Review Tool. Within those categories of standards are specific indicators or measures for compliance.

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<tr>
<th>Standard</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>A. Structural Integrity and Biographical Data</strong></td>
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<tr>
<td>1</td>
<td>All pages contain patient identification</td>
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<td><strong>B. Health Assessment</strong></td>
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<td>1</td>
<td>Advance Directive</td>
</tr>
<tr>
<td>2</td>
<td>Complete and current problem list</td>
</tr>
<tr>
<td>3</td>
<td>History and Physical</td>
</tr>
<tr>
<td>3.1</td>
<td>Medical and surgical history</td>
</tr>
<tr>
<td>3.2</td>
<td>Comprehensive physical exam every 1-2 years</td>
</tr>
<tr>
<td>3.3</td>
<td>Presence or absence of allergies</td>
</tr>
<tr>
<td>4.3</td>
<td>Date of medication refill</td>
</tr>
<tr>
<td>4.1</td>
<td>Name of Medication</td>
</tr>
<tr>
<td>4.2</td>
<td>Dosing information</td>
</tr>
<tr>
<td>4.3</td>
<td>Date of medication refill</td>
</tr>
<tr>
<td>5.1</td>
<td>Reason for visit/chief complaint</td>
</tr>
<tr>
<td>5.2</td>
<td>Physical Exam</td>
</tr>
<tr>
<td>5.3</td>
<td>Diagnosis/impression</td>
</tr>
<tr>
<td>5.4</td>
<td>Plan of treatment</td>
</tr>
<tr>
<td>5.5</td>
<td>Follow-up plan for each encounter</td>
</tr>
<tr>
<td>6.1</td>
<td>Consults, lab and test results reflect provider review</td>
</tr>
<tr>
<td>6.2</td>
<td>Follow-up for abnormal results</td>
</tr>
<tr>
<td>6.3</td>
<td>Hospital discharge summaries in medical record</td>
</tr>
<tr>
<td>6.4</td>
<td>Patient noncompliance addressed by provider</td>
</tr>
</tbody>
</table>
C. Counseling

<table>
<thead>
<tr>
<th></th>
<th>Diet/exercise</th>
<th>Relative to fat, cholesterol intake, evaluation of lifestyle and calcium for females.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Substance use &amp; abuse</td>
<td>Prevention and education relative to substance use is discussed (tobacco, alcohol, and other drugs)</td>
</tr>
<tr>
<td>3</td>
<td>Injury prevention</td>
<td>Use of seat belts, smoke detectors; domestic violence and other injury prevention measures.</td>
</tr>
<tr>
<td>4</td>
<td>Sexual practices</td>
<td>Will focus on individual risks that may endanger health.</td>
</tr>
</tbody>
</table>

LMCHP follows the preventive guidelines approved by the USPTF and others approved by accredited medical societies. Practice guidelines, as well as those used to make appropriate utilization decisions are shared with the Providers through the appropriate committees and are available to all upon request.
SECTION VII: MEMBER ACCESS TO CARE

It is the policy of Leon Medical Centers Health Plans that all members shall have access to healthcare on a timely basis.

- Emergency cases must be seen immediately. “Emergency Care” means medical services provided in response to a sudden medical condition that causes severe symptoms, such as severe pain, and that if not treated immediately, could reasonably be expected to place the member’s health at serious risk, seriously harm a body function, or result in serious damage to an organ or other part of the body.

- Urgent but non-emergency, must be seen within 24 hours. “Urgent Care” means medical services provided in response to a medical condition that causes urgent symptoms and which cannot safely be delayed until the member can come in for a routine visit.

- Non-urgent but in need of attention must be seen within 5 working days

- Routine and preventive must be seen within 30 days.

All Leon Medical Centers Health Plans members with scheduled appointments must have a professional evaluation within 30 minutes of the scheduled appointment time. If a delay is unavoidable, the member is to be informed and provided an alternative appointment if necessary.

After Hours

- After hours primary care/specialist services must be available to plan members with a medical condition that requires care before the physician’s next regularly scheduled office hours.

- The Primary Care Physician/Specialist or designee must be available to his/her members through an answering service. Physicians are expected to have twenty-four hour availability seven days a week through an appropriate call and/or coverage system. If an answering machine is utilized after hours, it should provide direction for emergency care and/or provide a phone number for physician accessibility. Covering physicians should be LMCHP participating physicians. LMCHP will routinely monitor performance against these standards.

- The Primary Care Physician/Specialist or designee must contact the member within 30 minutes for non-urgent calls and within 10 minutes for urgent calls.
The Primary Care Physician/Specialist must provide medical care as may be appropriate for the member or otherwise direct the member’s care as may be appropriate for the member’s medical condition and symptoms.
SECTION VIII: RIGHTS AND RESPONSIBILITIES

MEMBER

Members are treated with respect, consideration, and dignity.

Members are provided appropriate privacy.

Member disclosures and records are treated confidentially, and members are given the opportunity to approve or refuse their release, except when release is required by law.

Members are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

Members are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

Information is available to members and network provider staff concerning:
1. Member rights, including those specified above.
2. Member conduct, responsibilities, and participation.
3. Services available at the organization.
5. Fees for services.
6. Payment policies.
7. Members’ right to refuse to participate in research.
8. Advance directives, as required by state or federal law and regulations.
9. The credentials of health care professionals.

Prior to receiving care, members are informed of their responsibilities. These responsibilities require the member to:
1. Provide complete and accurate information to the best of his/her ability about his/her health, any medications (including over-the-counter products and dietary supplements), and any allergies or sensitivities.
2. Follow the treatment plan prescribed by the member’s provider and participate in his/her care plan.
3. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect care.
4. Accept personal financial responsibility for any charges not covered by his/her insurance.
5. Be respectful of all the health care professionals and staff, as well as others.

Members are informed of their right to change their network provider if other qualified network providers are available.
Members are provided with appropriate information regarding the absence of malpractice insurance coverage where applicable. Members are informed about procedures for expressing suggestions, complaints, and grievances, including those procedures required by state and federal regulations.

When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.

**PROVIDER**

This section of your Provider Manual is to serve as a reference for those rights and commitments you have acquired and agreed to through your contracted agreement with LMCHP.

**Rights**

1. You are encouraged to let LMCHP know if you are interested in serving as member of any workgroups or committees that may be formed by LMCHP.
2. You are encouraged to provide feedback and suggestions on how service may be improved within our organization.
3. You are entitled to have an LMCHP member removed from your care if an acceptable provider-patient relationship cannot be established with a member who has selected you as a caregiver. The request should be based on one of the following terms:
   - Inability to establish/maintain satisfactory patient/provider relationship
   - Failure of the member to pay the member responsibility, i.e. co-pay, coinsurance
   - Non-compliant, abusive or threatening behavior
   - Document in detail within a certified letter addressed to LMCHP at the following address:

   **Leon Medical Centers Health Plans**
   **Attn: Network Operations Department**
   **8600 NW 41st Street, Suite 201**
   **Doral, FL 33166**

Patterns of over-utilization either known or experienced as a chronic or catastrophic disease, are not grounds for discharging members from your care. The provider should make every effort to educate the member regarding potential plan benefit abuses, and if a situation arises where the member habitually abuses his or her benefits, LMCHP should be notified so that appropriate action can be taken regarding that member. This action may include member education either by a letter or telephone call, or personal contact, non-renewal of coverage and deletion from coverage.
4. You are entitled to submit administrative grievances of any kind to LMCHP and should expect resolution or explanation within 30 days.

5. You are entitled to appeal any pre-service medical determinations and any post-service appeals within 60 days of the decision.

6. You are entitled to request a peer-to-peer review with the Chief Medical Officer of LMCHP or designee to discuss an adverse medical determination.

Responsibilities

1. Provider shall provide services upon referral from Primary Care Physician, Specialist or LMCHP and work closely with the referring provider, if applicable, regarding the treatment the member is to receive.

2. Provider shall arrange for another provider to provide such services on your behalf in the event that you are temporarily unavailable or unable to provide patient care to a member. The coverage cannot be provided by an emergency room. The “covering provider” must agree to seek payment from LMCHP for covered services rendered to members and agree not to bill or seek payment from the member.

3. Provider shall utilize LMCHP participating providers and facilities when services are available and meet your patient’s needs.

4. Provider shall educate members regarding their health needs; share findings of the member’s medical history and physical examination with LMCHP, as necessary for continuity of care and referral purposes; discuss potential treatment options, side effects, and management of symptoms (without regard to plan coverage); and recognize that the member has the final say in the course of action to accept among clinically acceptable choices.

5. Provider shall provide continuing care to members under the terms of the Provider’s agreement with LMCHP.

6. Provider shall not provide services which require an authorization without such authorization or payment may be refused by LMCHP.

7. Provider shall not balance bill a member for providing services that are covered by the member’s Plan (This excludes collection of standard co-pays, deductibles, and co-insurance). Provider may bill a member for a procedure that is a non-covered benefit if Provider has followed the procedure defined by LMCHP.

8. For any medical records or other information Provider maintains with respect to Members, Provider must establish procedures to (a) safeguard the privacy of any information that identifies a Member; (b) release information from, or copies of, records only to authorized individuals; (c) ensure that unauthorized individuals cannot gain access to or alter Member records; (d) release original medical records only in accordance with Federal and State laws, court orders, or subpoenas; (e) maintain the records and information in an accurate and timely manner; (f) ensure timely access by members to the records and information that pertain to them; and (g) abide by all state and federal laws regarding confidentiality and disclosure for mental health records, medical records, other health information and Member information.

9. Provider acknowledges and agrees that all marketing activities related a Benefit Program must conform to the requirements of the Medicare Advantage program, as amended from time to time. Provider and LMCHP will not engage in any such
marketing activities related to their contractual obligations, directly or indirectly, without first obtaining CMS approval.

10. Provider agrees to provide Covered Services in a manner consistent with professionally recognized standards of health care and further to (a) provide Covered Services in a culturally competent manner to all members by making a particular effort to ensure that those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the healthcare to which they are entitled; (b) provide Members information regarding treatment options in a culturally competent manner, including the option of no treatment; (c) ensure that Members with disabilities have effective communication with representatives of Facility in making decisions regarding treatment options. LMCHP and Provider will work together to ensure that (i) an initial assessment of each enrollee’s health care needs, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment; (ii) Provider maintains an enrollee health record in accordance with professional standards of healthcare and LMCHP policies and procedure; (iii) there is appropriate and confidential exchange of information among all Providers in order to maintain continuity of care for LMCHP enrollees. Provider will deliver all Covered Services in a manner consistent with professionally recognized standards of health care.

11. Provider acknowledges and agrees to assist LMCHP in making a good faith effort to notify all affected Members of the termination of a provider contract within 30 days of notice of termination by LMCHP or Providers.

12. Provider agrees to comply with LMCHP’s medical, quality and medical management policies as required by CMS. Provider further agrees to consult with LMCHP in the development of such policies.
SECTION IX: CLAIMS

By entering into an Agreement with Leon Medical Centers Health Plan, the Provider has agreed to accept payment directly from Leon Medical Centers Health Plans. Payment from Leon Medical Centers Health Plans, plus any applicable co-payment or coinsurance from the Member constitutes payment in full for the services rendered. This means that the Provider may not bill Members for the difference between billed charges and the contracted reimbursement amount.

Claims are processed according to Centers for Medicare Services (CMS), American Medical Association (AMA), and National Correct Coding Initiative (NCCI) guidelines.

**Clean Claims**
A claim that has no defect or impropriety and which requires no further information, adjustment or alteration by Provider, per CMS guidelines, in order to be processed or paid by Leon Medical Centers Health Plans.

It is the goal of Leon Medical Centers Health Plans’ Claims Department to provide the most efficient and accurate processing of claims. In order to avoid delays in processing, we require that all claims be submitted on industry standard HCFA/UB04 forms, either by mail or electronically. When billing for surgical/procedure services, medical notes must be submitted to support the level of care billed.

The suggestions below would assist in the efficient and accurate processing of your claim.

- Paper submissions should be typed not hand written.
- Indicate the Member’s/Patient’s ID with Leon Medical Centers Health Plans as listed on their card by your HCFA/UB04 Insured’s ID field. Refrain from using the Member’s/Patient’s Social Security Number.
- Member’s/Patient’s date of birth.
- Provider of service, NPI, and Tax ID.

**Coordination of Benefits (COB) and Subrogation**
Leon Medical Centers Health Plans may have to Coordinate Benefits in cases where a Member/Patient has another insurance carrier that duplicates or overlaps with their Leon Medical Centers Health Plans coverage.

Leon Medical Centers Health Plans may have subrogation rights in cases where a third party, may be responsible for paying for a Member’s/Patient’s medical care.

All documentation or information related to COB, Third Party Liability, etc. should be attached to the HCFA/UB04 claim form for prompt adjudication of claim.
In the event that another Carrier is noted and the Provider is not sure which insurance is primary, the Provider should contact our Member Services Department at (305) 559-5366 or 1(866)393-5366.

**Claim Submissions**
All fee-for-service claims and encounter data should be sent to:

**Submit Paper claims to:**

Leon Medical Centers Health Plans  
Attn: Claims Department  
P.O. Box 66-9441  
Miami, FL 33166

**Submit Electronic claims to:**

Leon Medical Centers Health Plans Payor ID:

- ENS 37316
- Web MD 37316
- Availity 65055

**Mental Health Claims**
Leon Medical Centers Health Plans has contracted with Psychcare, Inc to provide all services related to mental health. This includes prior authorization and processing of claims.

**Submit Psych claims to:**

Psychcare, Inc.  
10200 Sunset Dr.  
Miami, FL 33173

Toll free number: 1 (800) 221-5487

**Timely filing**
Claims or encounter data must be submitted within ninety (90) days of the date of service for payment to be considered unless otherwise stipulated in your contract. Upon receipt of a Clean Claim, Leon Medical Centers Health Plans agrees to reimburse or provide written notice to Provider no later than forty-five (45) days from receipt of complete claim.

**Claims Status**
If you have not received an Explanation of Benefits (EOB) from Leon Medical Centers Health Plans within 45 days of submitting a claim, please check the status of your claim.
on-line by using our Health Web Portal or calling our Claims Department at (305) 631-5343.

Health Web Portal:  
http://lmcportal.lmchealthplans.com/

**Claims Review**  
A provider may request a review of the adjudication on a claim regarding services or reimbursement covered under their contract within (60) days, unless otherwise stipulated on contract, from receipt of an Explanation of Benefits (EOB) from Leon Medical Centers Health Plans by requesting such review in writing or by calling our Claims Department at (305) 631-5343.

In the event that a Provider is not in agreement with the outcome of the review of an adjudicated claim, the Provider may appeal.

**Claims Appeal**  
Provider shall have sixty (60) days, unless otherwise stipulated on contract, from receipt of an Explanation of Benefits (EOB) from Leon Medical Centers Health Plans within which to request a 1<sup>st</sup> level appeal for adjudication of a claim. If the 1<sup>st</sup> level appeal is upheld, the provider will have an additional 60 days from the date of the level 1 appeal notice to request a 2<sup>nd</sup> level review.

Provider can request an appeal of a claim in writing by completing the Provider Appeal Request Form found in the Forms section of this manual or by submitting a letter addressing the reason for an appeal.

**Submit Appeals to:**

Leon Medical Centers Health Plans  
Attn: Appeals Department  
P.O. Box 66-9440  
Miami, FL 33166

You may check the status of your appeal by calling our Appeals Department at (305) 631-5348.
SECTION X: EDI & HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed to implement a nationwide standard for transaction and code sets to be used by the electronic industry. Among those transactions is the electronic transfer of health information. The electronic data interchange (claims data) between a provider and Leon Medical Centers Health Plans is referred to as EDI. Providers are not required to submit claims data electronically and/or receive an electronic remittance advice; HIPAA does require the use of standard transaction and code sets.

Leon Medical Centers Health Plans accepts electronic data both directly and through one of the clearinghouses. For more information on EDI and HIPAA, please contact the health plans information systems department.

Confidentiality
In accordance with HIPAA, all Leon Medical Centers Health Plans practitioners, providers and their staff are required to safeguard and protect the confidentiality of Leon Medical Centers Health Plans members’ Protected Health Information (PHI). Member PHI must be secured only where authorized personnel can obtain access. Medical records cannot be disclosed to unauthorized personnel without the written request of the member or as otherwise authorized by law.

Leon Medical Centers Health Plans is very sensitive to privacy issues and therefore has strict policies and procedures in place to ensure that we protect and safeguard confidential, sensitive and proprietary information regarding the members, practitioners and providers. Access to confidential information is restricted to employees, practitioners, suppliers and vendors of Leon Medical Centers Health Plans on a need to know basis. However, the minimum necessary standard does not apply to treatment.

Protection of PHI
Leon Medical Centers Health Plans’ corporate confidentiality policy protects oral, written and electronic PHI internally across the organization. Business associates enter into a Business Associates Agreement with Leon Medical Centers Health Plans to protect the use and disclosure of PHI. Oral PHI is protected internally by requiring proof of identity. Leon Medical Centers Health Plans protects written PHI, for example: locked files and desks, locked recycling bins, shredding, and document retention policies. Leon Medical Centers Health Plans protects electronic PHI by, among other things, assigning employees computer access level, computer passwords, passwords on screen savers, file encryption, and firewalls.
Member’s Rights Regarding PHI
Each Member is provided with a Notice of Privacy Practices upon enrollment. The Notice of Privacy Practices contains information describing the member’s rights regarding the PHI that Leon Medical Centers Health Plans maintains. The Notice of Privacy Practices includes:

- The right to request a restriction on uses and disclosures of his or her PHI
- The right to confidential communication
- The right to access his or her PHI
- The right to amend his or her PHI
- The right to file a complaint
- The right to a paper copy of Leon Medical Centers Health Plans’ Privacy Notice

Use and Disclosure of PHI
Leon Medical Centers Health Plans is not authorized to disclose a member’s own medical record to the member. The member must obtain medical record information from the practitioner, provider or facility that is the original source of such records.

Leon Medical Centers Health Plans may use and disclose member PHI for routine purposes that include treatment, payment and healthcare operations. Although Leon Medical Centers Health Plans is permitted under federal law to make disclosures for treatment purposes, as a health maintenance organization, Leon Medical Centers Health Plans does not perform any treatment functions. Therefore, none of Leon Medical Centers Health Plans’ uses and disclosures of PHI are for Leon Medical Centers Health Plans’ treatment purposes.

Disclosure for Payment Purposes
Leon Medical Centers Health Plans may use and disclose member PHI for payment purposes. For example, Leon Medical Centers Health Plans uses PHI to determine Leon Medical Centers Health Plans’ responsibility for the provision of benefits. Leon Medical Centers Health Plans may also disclose PHI for the purpose of conducting utilization review activities, such as providing preauthorization of services.

Additional purposes for which Leon Medical Centers Health Plans may use PHI information includes:

- Concurrent and retrospective review of services
- Claims management
- Adjudication or subrogation of claims
- Coordination of benefits
- Determination of coverage
- Billing and collection activities
Disclosure for Healthcare Operations
Leon Medical Centers Health Plans can use and disclose PHI to allow Leon Medical Centers Health Plans to conduct healthcare operations, including many administrative activities. For example, Leon Medical Centers Health Plans may use member PHI in peer review activities that involve reviewing the competence and performance of healthcare professionals. Leon Medical Centers Health Plans may also disclose member PHI for the purpose of obtaining accreditation from state and federal agencies and organizations, including AHCA, CMS, AAAHC, and for HEDIS measurements.

Authorizations for Disclosure of PHI
A member has the right to request Leon Medical Centers Health Plans to disclose his or her PHI pursuant to a specific written authorization signed by the member or the member’s personal representative. Leon Medical Centers Health Plans will obtain a written authorization for uses and disclosures of PHI that are not for treatment, payment or healthcare operations or for uses and disclosures that are not otherwise required by applicable law. Requests for an individual’s PHI, other than those required by law or for treatment, payment and healthcare operations, will be denied. If a member does not authorize the release by submitting a valid authorization, Leon Medical Centers Health Plans required specific, written authorization or court order for disclosures related to:

- Alcohol and drug abuse treatment records
- Sexually transmitted disease treatment records
- Mental health records
- HIV/AIDS records

A member may revoke, in writing, at any time, an authorization regarding the use and disclosure of PHI, except to the extent that Leon Medical Centers Health Plans has already used or disclosed the PHI.
SECTION XI: CREDENTIALING

CREDENTIALING
All providers who wish to participate in LMCHP are subject to a comprehensive application review process during which primary source is used to verify appropriate licensure, education and conformance to all the Plan’s acceptance criteria. LMCHP’s credentialing policies and procedures are based on AAAHC standards and include all credentialing requirements mandated by state and federal and NCQA guidelines. Practitioners who complete the application process are reviewed by the Plan’s Credentialing Committee. The Credentialing Committee meets monthly to review all initial and recredentialed applicants and makes recommendations with regard to their acceptance and/or continued participation in LMCHP’s network. Providers who are accepted into the Plan are required to recredential at least once every three years or earlier if requested by the Credentialing Committee in order to maintain their participating status.

Providers Subject to the Credentialing and Recredentialing Requirement include but are not limited to the following provider types:

Practitioners: MD, DO, DPM, DDS, DC, OD, PHD, PT, OT, CRNA
Ancillary-Facility Providers: Hospital, Surgery Center, Home Health Agency, Durable Medical Equipment, Laboratories, Diagnostic/Radiology Services, Skilled Nursing Homes, Physical Therapy Center, Urgent Care Clinic, Federally Qualified Health Clinic

General Participation Requirements
Any Provider who wishes to be a participating provider in LMCHP’s network and is contracted for the network is required to submit the following requirements.

- Complete, sign and date credentialing application
- Current Curriculum Vitae
- Current Medical Professional License
- Current DEA Certificate (if applicable)
- ECFMG Certificate (if applicable)
- Copy of Medicare approval letter
- Medical School, Internship and Residency Certificates
- Current Board Certification (if applicable)
- Copy of NPI number and Taxonomies number (e-mail confirmation)
- Current Malpractice Coverage Face Sheet
- Financial Responsibility Form if you do not carry Malpractice Coverage
- Occupational License (if applicable)
- Copy of Florida Drivers License
- Completed and signed W-9 form
- Letter of recommendation from a peer
• Scope of Privileges Form

CAQH
Starting in 2014, Leon Medical Centers Health Plans is also a CAQH participating organization. Providers that have registered with CAQH’s Universal Provider Data source can authorize Leon Medical Centers Health Plans to have access to their profile. This will allow the Plan to credential and re-credential you more effectively. The Plans number with CAQH is 764.

INITIAL CREDENTIALING PROCESS
Once a provider has submitted an application for initial consideration, LMCHP’s Credentialing Department will conduct primary source verification of the applicant’s current and previous licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action and malpractice history by querying the National Practitioner Data Bank. A Network Operations representative will schedule and conduct an office survey, if required. The credentialing process generally takes up to ninety (90) days to complete but can in some instances take up to 180 days. Providers will be notified in writing within 60 days when credentialing has been completed and their application has been approved by the Credentialing Committee and assigned an effective date.

RECREREDENTIALING PROCESS
All providers are required to recredential with the Plan at least every three years in order to maintain their participating status. The Credentialing Department will notify participating providers at least four (4) months prior to their credentialing due date that they must update their credentials file. Updates to the original application include a current recredentialing application form and attestation, current copies of any licensure, malpractice or board certification and all changes in work history, education, privileges, health status, malpractice history or disciplinary/adverse actions that have occurred since the previous credentialing cycle. The Credentialing Specialist will send at least three (3) separate requests to non-responsive providers in order to obtain recredentialing information. Providers who fail to return recredentialing information prior to their credentialing due date will be notified in writing of their termination from the network.

Credentialing/Re-credentialing Procedures
The Credentialing Department is responsible for processing the provider’s application and the primary source verification of the items listed above in an accurate and timely manner. All information considered in the credentialing process must be obtained and verified within 180 days immediately prior to the final decision of the Credentialing Committee. In the event that information submitted by the provider differs from the information obtained through verification, the provider will be notified in writing of the discrepancy and of his/her right to review and/or amend the erroneous information.
CREDENTIALING COMMITTEE
LMCHP’s Credentialing Committee is comprised of participating primary care and specialist providers, administrative staff and overseen by the Plan’s Chief Medical Officer or designee. The purpose of the Committee is to make recommendations toward credentialing decisions on all initial and recredentialed providers, evaluate the credentialing program and review and amend the credentialing policies and criteria as needed. The Committee meets monthly or at least ten (10) times annually.

The recommendation of the Credentialing Committee shall fall into one of the following categories: Approved, Conditional Approval, Deferred/Pended or Denied/Terminated. In the event of a Committee denial, the provider will receive a notice via certified mail within 60 business days of Credentialing Committee’s decision. Upon receipt of the notification from the Plan, the provider may submit a written request for an appeal. The request must contain details of the practitioner’s issues with the decision or with the decision making process. The appeal must be received by the Plan within 30 calendar days of the date of receipt of the written notice of denial, suspension or other disciplinary action.

CONTRACTS
LMCHP may at times terminate or suspend agreements with participating providers. Termination may be based on a change in business needs, provider breach of contract terms, or other reasons which may necessitate contract termination. Terminations will be handled in compliance with law and contractual obligations. Provider acknowledges and agrees to assist LMCHP in making a good faith effort to notify all affected Members of the termination of a provider contract within 30 days of notice of termination by LMCHP or Providers. LMCHP agrees to notify Provider in writing of reasons for denial, suspension or termination. Furthermore, LMCHP and Provider agree to provide at least 90 days notice or as stipulated in the contract between LMCHP and provider.

DELEGATION
Any activities that are contractually delegated by LMCHP (e.g. Credentialing) must adhere to standards and/or requirements as imposed by the Delegation Agreement and Delegation Policy and Procedures. A delegation packet is forwarded by request to potential delegate, who itemizes the delegation process and requests required materials for review and approval. A desktop review is conducted to determine the ability of the delegate to conduct the requested activity in conformance with the Plan’s standards. If delegation is considered appropriate, an on-site audit is conducted by appropriate LMCHP personnel. Any potential delegate must meet the standards imposed by LMCHP, Medicare and the Accreditation Association for Ambulatory Health Care (AAAHC) for consideration of any delegated activities.

PROVIDER SITE VISIT SURVEY –
As part of the initial assessment and at re-credentialing, an on-site review will be conducted on all hospitals, skilled nursing facilities, free-standing surgical centers, home
health agencies and inpatient, residential or ambulatory mental health or substance abuse
centers that do not hold acceptable accreditation status.
LMCHP may accept a copy of the organization’s most recent state or CMS survey in lieu
of an on-site assessment. If deficiencies were noted on the state or CMS survey, the
provider must include a copy of the corrective action plan submitted to the State or CMS
auditor. At LMCHP’s discretion, the provider may be required to provide additional
documentation to demonstrate compliance with the corrective action.
For all other types of facilities and ancillary service providers, site visits will be
performed when indicated subsequent to receipt of a complaint.
The Patient Self-Determination Act was enacted by Congress as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. It required all physicians, hospitals, nursing facilities, home health care agencies, hospices and HMOs and EPOs participating in Medicare to provide written information to adult patients about their right to institute “advance directives.”

The Provider must document in a prominent part of the individual’s current medical record whether or not the individual has executed an advance directive. [42 C.F.R. § 422.112(b)(4)]; therefore, the following booklet is provided in this manual to assist you in preparing any patient for a time when they are unable to direct their healthcare needs.

The legal documents that can be used by a patient to give the directions in advance are called “advance directives”. There are different types of advance directives and different names for them. Documents, called “living will” and “power of attorney for health care” are examples of advance directives. Below is an example of each.

**Living Will:**
Gives instructions for how the patient wishes medical treatments to be used at the end of life. It can be used to specify the extent of medical intervention that a person wants, including a “Do-Not-Resuscitate Order” or DNRO. A “DNRO” is written order instructing healthcare providers not to attempt cardiopulmonary resuscitation if the patient stops breathing or the heart stops beating. A DNRO must be signed by a physician to be valid. Other names for this document include “directive to physicians,” “healthcare declaration,” or “medical directive.” The document’s purpose is to guide the patient’s family and doctor in honoring the patient’s wishes about the care provided near the end of life.

**Power of Attorney (POA):**
Appoints a particular person to make medical decisions for a person who can no longer make decisions. This may also be called “appointment of a healthcare agent,” or “durable power of attorney for healthcare.”

The Centers for Medicare-Medicaid Services (CMS) regulations do not require that “Advance Directives” be filled out, but that “Advance Directive” counseling is provided. The following booklet meets the requirements of “Advance Directive” counseling. Please provide a copy of this booklet to each new patient as they present themselves to your office or facility.

*Advance Directives booklet located in the Forms section*
THE QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program is an ongoing, objective and systematic process which reviews and evaluates the quality and appropriateness of healthcare services delivered by Leon Medical Centers Health Plan, Inc. providers. The program’s objective is to identify opportunities to improve care and resolve identified concerns. All Peer Review Utilization Management and Quality Management and Quality Management activities are under the supervision of the Chief Medical Officer of LMCHP or designee.

Leon Medical Centers Health Plans’ Quality Improvement Program is designed to assess the manner in which health services are provided to healthplan Members, to identify differences (medical, administrative, fiscal) within the health services delivery system, and most importantly, to plan and implement appropriate corrective actions. The Leon Medical Centers Health Plans Quality Improvement Program has an identifiable structure, specific objectives and a coordinated process for all program activities.

An ongoing, formalized system of review will be conducted by the Provider Relations Department and Health Services Department under the auspices of the Chief Medical Officer of LMCHP or designee. Types of reviews that will be performed include:

- Re-credentialing every 3 years
- Random quality of care studies
- Member and physician satisfaction studies
- Utilization Management Program

Leon Medical Centers Health Plans recognizes that the highest quality health care and administrative services for Members and Participating Providers are most often achieved by establishing goals, objectives and techniques for achieving the goals and, then, concurrently measuring attainment of the goals. The overall goals of the Quality Improvement Plan are to:

- Promote and build quality goals into Leon Medical Centers Health Plans’ organization structure and processes by:
  - Facilitating a partnership between participating Providers, Members and Plan staff for the continuous improvement of health care delivery and;
  - Improving communication and providing education to all staff, Providers and Members regarding the quality goals.

- Providing effective concurrent monitoring and evaluation of patient care and services to meet the requirements of good medical practice and be perceived positively by Members and Participating Providers by:
  - Developing, implementing and evaluating guidelines of medical practice.
  - Developing administrative guidelines related to quality management activities such as but not limited to access, availability, credentialing and peer review, and surveying members and participating providers regarding their satisfaction with health care and administrative services.
- Ensure prompt identification and analysis of opportunities for improvement with implementation of actions for resolution and follow-up by:
  o Identifying important problems and concerns regarding health care services provided to the Members, recognizing that each segment of the membership may have unique concerns.
  o Continually assessing the success of the Leon Medical Centers Health Plans Quality Management Plan in defining and achieving goals, and
  o Providing regular feedback to the Participating Providers, Members and Plan staff regarding attainment of quality management goals.

- Coordinate activities and communication between the various functions of the Quality Improvement program by:
  o Defining annual goals and objectives and coordinating the development of techniques to attain the goals with the appropriate functions within the Quality Improvement program,
  o Establishing Committees and communication lines which assure the sharing of data, and
  o Creating an operational structure which allows immediate action to be taken to address significant quality or process improvement issues.

- Maintain compliance with local, state and federal regulatory requirements and accreditation standards by:
  o Monitoring regulatory requirements for the various functions included within the Quality Improvement program and amending the technique as needed, and
  o Implementing techniques and creating outcome reports and profiles in such a way as to meet regulatory or accreditation requirements.

Scope of Services and Quality Management Program Methodology

Scope of Services
The scope of the Quality Improvement Program will provide an ongoing system for monitoring and evaluating the quality and appropriateness of the care and services provided to members and to pursue opportunities for improvement. The Quality Improvement Program is comprehensive and includes both the important aspects of the quality of clinical care and quality of service provided. Information will be collected on functions that have the greatest impact on patient care, services and clinical performance, whether or not problems are suspected. The findings of quality improvement activities are used to improve the processes that affect patient care, services, outcomes, identify educational needs and determine clinical competence of employees and health care providers. The monitoring and evaluation of clinical care reflect components of the delivery system and full range of services. Quality Improvement clinical indicators and studies are elected based upon the population serviced by Leon Medical Centers Health
Plans in terms of age group, disease categories, high volume and high risk status and include measurement of:

- Services provided by institutional settings such as hospitals, skilled nursing facilities, long term care and rehabilitation.
- Services provided in non-institutional settings such as home health care, free standing surgical centers, urgent care, emergency room, physical therapy and pharmacy.
- Primary care and high volume specialists.
- Preventive health guidelines and quality of care.
- Continuity and coordination of care.
- Under and over utilization

**Quality Improvement service indicators and performance goals will be established for:**

- Physician accessibility
- Physician availability
- Health plan accessibility
- Member satisfaction surveys
- Complaint and grievance monitoring and analysis
- Provider satisfaction and department performance monitors
- Adverse events
- Ambulatory medical record review
- Provider non-compliance with managed care
- PCP change rate
- Well visit rates for PCPs
- PCP and high volume specialist office visit
- Provider financial profiling
- Provider non-financial profiling

**Administrative Performance Measures**

- Access to care
- Management of Appeals and Grievances from providers and members
- Credentialing of providers
- Claims payment
- Member disenrollment
- HEDIS/CAHPS/HOS

Leon Medical Centers Health Plans monitors organization-wide against performance goals reflecting services and clinical care outcomes. These indicators are trended and reported at least quarterly to the QIC.

**Quality Improvement Program Methodology**

The monitoring and evaluation process is designed to focus on potential areas for improvement in patient care and program services. The following steps comprise the basic approach:
• Assign responsibility for monitoring and evaluating activities
• Identify the most important aspects of care provided
• Identify indicators and appropriate clinical criteria for monitoring the important aspects of care
• Establish performance thresholds (levels, trends, patterns) for the indicators that trigger evaluation of care
• Monitor the important aspects of care by collecting and organizing the data for each indicator
• Evaluate care when thresholds are reached in order to identify other opportunities to improve care or problems
• Take action to improve care or to correct identified problems
• Assess the effectiveness of the actions and document the improvement in care
• Communicate the results of the monitoring and evaluation process to relevant individuals, departments or services

The continuous effort toward improvement is led by management. All employees are provided with training and education to keep them informed of their role in continually providing and improving the quality of service. The Internal Quality Management Committee provides ongoing interdepartmental oversight to assure continuity, integration of activity and continuous improvement.

Clinical Performance Measures
• Adhere to Standards of Care Criteria as set in UM policies, QI program, risk management
• Provider Satisfaction
• Member Satisfaction
• Denials and Appeals
• Continuity of Care
• Preventive Services
• HEDIS/CAHPS/HOS

Quality Improvement Program Activities
Quality Improvement activities utilize a variety of mechanisms to measure and evaluate the total scope of services provided to Leon Medical Centers Health Plans Members. The following components are included in the Quality Improvement Plan:

Adverse Event Evaluation
The objectives of the Adverse Event Evaluation are to:
• Identify patterns of adverse events that suggest opportunity for process improvement.
• Ensure that individual cases, identified as risk management issues, are evaluated by the Chief Medical Officer of LMCHP or designee.
An adverse event is an untoward event that happens to a Member. The Member’s certification information, medical record, claim/encounter history, or a Provider Profile, serves as data sources. The data is analyzed in the aggregate for trends to identify broad opportunities for Committee and Quality Management Committee for review and recommendation.

Individual cases with a high potential for becoming a risk management issue are forwarded immediately to the Risk Management Department. The staff of the Utilization Management or Customer Service department predominantly identifies these cases. The Risk Management Department will research and evaluate the problem and conduct peer-to-peer review as appropriate. The Risk Management Department will summarize and report their findings at the next scheduled meeting of the Quality Management Committee. The intent of this process is to identify and resolve quality and servicing problems in a timely manner.

Confidentiality of Patient Information Policy
Leon Medical Centers Health Plans staff will not directly or indirectly reveal, report, publish, disclose, or transfer any of the information which is designated as confidential except to authorized persons, as noted in the Disclosure section below.

Medical information concerning patients and credentialing information regarding physicians and/or facilities shall, therefore, not be released without a properly written release form.

PURPOSE
Federal and state regulations exist which are designed to safeguard the rights and privacy of enrollees in a health benefit plan. These statutes ensure that confidentiality for utilization review, case management, and quality assurance activities is maintained and the proprietary information is protected from unauthorized disclosure.

PROCEDURE
Upon employment all Medical Management staff will sign a Confidentiality and Non-Disclosure Agreement.

Any medical information will be used solely for the purposes of utilization review, case management quality assurance, and claims adjudication, and shared only with those parties who have authority to receive such information.

Disclosure is considered necessary in the performance of utilization review, case management and quality assurance activities, if it is made to these individuals:

- Providers who are actively engaged in designing or implementing a treatment plan.
- Government agencies when required to fulfill their legal responsibility. When appropriate documentation is included as to the purpose for requesting the information and the legal responsibility held by the government agency.
If disclosure is required through a court order, the Vice President of Health Services will be notified to determine the legitimacy of the order, what information is ordered, the purpose for the disclosure, and limitations on the information to be disclosed.

All patient specific medical information will be stored, for the appropriate length of time as required by legal statute, in files that are secured and made accessible only for the purpose stated above. System-stored patient specific medical information will be protected through system security levels which prevents access to unauthorized staff.

Confidentiality shall also be secured through the prevention of conflict of interest by employees. Leon Medical Centers Health Plans shall determine if employment with an additional company or ownership of any portion of stock in another company represents opportunity for release of confidential information.

Upon employment, each employee shall be required to execute both:

1. Confidentiality Statement
2. Statement of Disclosure
Leon Medical Centers Health Plans Utilization Management Department is committed to the principles of quality care and cost containment. The management mechanisms are designed to assure appropriateness of care and identify alternative methods of providing health care while maintaining the highest level of care possible in the most cost effective manner.

Referral Management
- Enhances quality and cost effectiveness.
- Determines benefit eligibility based on medical necessity before services are rendered, according to the Member’s Certificate of Coverage.
- Directs referrals to contracted providers.
- Monitors member and provider compliance.

Prior Authorization Requirements
- To ensure appropriateness of care and prevent unnecessary cases from occurring.
- To ensure that care takes place in the most appropriate setting.
- To notify the concurrent review system that a case will be occurring.
- To capture data for utilization statistics and financial accruals.

Inpatient Prior Authorization
All inpatient admissions must be approved based on medical necessity, as determined by Leon Medical Centers Health Plans. Admissions should be precertified in advance if elective, and within 24 hours if urgent/post-stabilization. Precertifications should be initiated by the Member’s Primary Care Physician or Specialist or the hospital in the case of urgent/post-stabilization admissions.

Information needed for prior authorization includes:
- Member’s ID Number
- Diagnosis
- Clinical history
- Surgical or other procedures to be performed
- Admitting provider
- Admitting facility
- Additional insurance coverage
- Date of injury, if applicable
- Anticipated admission date
- Abnormal clinical findings
- Anticipated problems with anesthesia
- Pertinent procedures performed, abnormal results, and dates
For members who go to an emergency room for treatment, an attempt should be made in advance to contact the Primary Care Physician unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a Member appears at an emergency room for care which is non-emergent, the Primary Care Physician should be contacted for direction. All urgent/post-stabilization admissions must be reported by Leon Medical Centers Health Plans within 24 hours of admission. Please be prepared to discuss the Member’s condition and treatment plan with our coordinator.

**Concurrent Review**

Concurrent review is designed to monitor the quality appropriateness of ongoing treatment for Members. The clinical staff will be monitoring the Member’s progress. The coordinator will either perform an onsite review of the medical record or contact the provider for medical record information which will be necessary to certify additional days of care and facilitate discharge planning.

The coordinator may contact the attending physician during the Member’s hospitalization to determine what necessitates continued stay and to discuss discharge planning. If the Participating Physician indicates the Member’s need for further hospitalization no longer exists, or is unwilling to consider other alternatives to hospitalization, contractual terms may dictate termination of inpatient benefits but only after review by the Chief Medical Officer of LMCHP or designee.

The determinations are not treatment decisions or recommendations. Participating Physicians are responsible for making medical treatment decisions in consultation with their patients. Request for reconsideration of benefit determinations will be handled in accordance with the procedure described in the members Evidence of Coverage.

**Case Management**

Case Management focuses on the early identification of the Member with potentially long term and/or high cost needs, complex medical needs or members taking part in a disease management program. The plan acts as the Member’s advocate by working with the attending Participating Physician, other providers of care or services, the Member and family to identify, assess, and recommend alternative treatment programs. Case Management may also focus on multiple hospital admissions and offer appropriate alternatives to hospitalization.

**Identifying Members Who May Benefit**

Members with, but not limited to, chronic or terminal illnesses may benefit from this program. Please refer to the following list of diagnoses which indicate case management may be beneficial.
When to Refer
Since early detection of cases is essential, a Member may be referred when a diagnosis has been established. However, Members may be referred anytime during an illness when an alternative treatment may be beneficial.

How to Make a Referral to Case Management
If you think your patient may benefit from case management, you may call the Utilization Management Department at:

☎️ (305) 631-5345

Examples of cases followed in Case Management are:

- A.I.D.S./A.I.D.S. Related Complex
- Chronic Pulmonary Disease
- Patients requiring prolonged rehabilitation services
- Chronic Conditions with Actual/Potential Exacerbations, i.e., Diabetes, Chrohn’s Disease
- Congenital Anomalies
- Patients with CHF (Stage C & D)
- Hospice Referrals
- Infectious Processes requiring long term treatment
- Multiple Traumas
- Parenteral/Enteral Therapies
- ESRD patients
- Severe Burns
- Terminal Illness
- Traumatic Brain Injury
- Transplants
- Ventilator Dependent Members
- Patients requiring complex wound care
- Patients with multiple hospitalizations per year or requiring multiple specialities

Disease Management Program
The disease management program supports the member’s physician’s treatment plan. It adds to, but does not replace, the member’s physician care. Our Care Coordinators, a team of registered nurses, and other professionals, add an important human element to the member’s care between doctor visits. The Care Coordinators reach out to members with specific diagnosis to help facilitate positive change through member education, self-management techniques, monitoring compliance and adherence to treatment plans and identification of barriers to care and need for social and community resources.
The referral/authorization process is an important component of Leon Medical Centers Health Plans Quality Improvement and Utilization Management Programs. The referral/authorization process must be used by all participating PCPs and specialty physicians to assure that the member receives the maximum benefit and that the claim is paid. When a Leon Medical Centers Health Plans member requires medically necessary treatment that is beyond the scope of the primary care physician (PCP) or is a service not provided in his/her office, the member should be referred to the most appropriate provider of that medical service.

Leon Medical Centers Health Plans contractually requires that all PCPs and SCPs must coordinate and follow the member’s care and request referral authorization to specialty providers only when medically necessary. All referral requests for authorization must go through the plan UM Department to be reviewed for the following:

- Member eligibility verification
- Requested service is a covered benefit
- Requested service is medically necessary
- Coding is confirmed for claims payment
- Referred Provider is participating in the health plan
- Consistency with approved clinical practice guidelines and medical standards

Leon Medical Centers Health Plans supports a direct access process for some preventive specialty services. A patient is encouraged, however, to notify his/her PCP of services being rendered and the specialty provider is also responsible for submitting a consultation report back to the PCP.

The Leon Medical Centers Health Plans members may self-refer to a contracted provider for the following:

- Routine women’s health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams.

- This care is covered without a referral from your PCP when a contracted provider is utilized.

- Flu shots and pneumonia vaccinations obtained from a contracted provider.

- Emergency services, whether the member gets these services from plan providers or non-plan providers.

- Urgently needed care that members obtain from non-plan providers when they are temporarily outside the plan’s service area. Also, urgently needed care that the member gets from non-plan providers when they are in the service area but,
because of unusual or extraordinary circumstances, the plan providers are temporarily unavailable or inaccessible.

- Renal dialysis (kidney) services that members receive when they are temporarily outside the plan’s service area.
- Chiropractic services (as long as a contracted provider is utilized).
- Podiatry services (as long as a contracted provider is utilized).
- Dermatology services (as long as a contracted provider is utilized).
- Cardiovascular screening blood test services (as long as a contracted provider is utilized).

**Referral Process**

All medically necessary covered services provided outside the Leon Medical Centers must be authorized by the Plan. Prior to requesting a referral, the PCP documents the medical condition requiring a referral in the member’s medical record that includes the following:

- Primary diagnosis
- Additional diagnosis or secondary diagnosis, if applicable
- Description of requested services to be performed
- Specialty requested for consultation
- Reason for referral

When referring to a specialist, consult the Provider Directory for the name and provider number of the provider to whom you are referring to confirm his/her participation in the Leon Medical Centers Health Plans. If additional assistance is needed or if you need a current copy of the Provider Directory, please call the Network Operations Department at:

📞 305-646-3776, 305-631-5242 or
Member Services Department
📞 305-559-5366

All requests for a referral/authorization to any provider should be submitted via fax on a Leon Medical Centers Health Plans Referral/Authorization Form. For efficient processing, please assure that the Referral/Authorization Form is legible and complete. If additional medical information is required you will then be contacted by the Leon Medical Centers Health Plans UM Department. Failure to provide the necessary information could result in your patient’s requested medical services being delayed and/or claims payment denied. The Leon Medical Centers Health Plans Referral/Authorization Form can be found in the Forms section of this manual.
Leon Medical Centers Health Plans, Inc. has adopted the Medicare timeliness standards for the review and processing of authorization requests:

- **Urgent pre-service review** – 72 hours or less from time of receipt of request
- **Urgent concurrent review** - 24 hours or less from time of receipt of request
- **Non-urgent pre-service review** – 14 calendar days or less from receipt of request
- **Post-service review** – 30 days or less from receipt of request

Written denial notification – Sent to member and physician 3 business days or less from its decision but no later than 14 calendar days after receiving the request.

Within the timeliness standards above, the UM Department will review the referral request for medical necessity and/or benefits coverage and then generate a referral authorization and number which will be communicated to the referring PCP or the provider who is rendering the medical services that were requested; at this point the requesting provider has the responsibility of notifying our member, your patient that these services have been approved; the appointment will then be scheduled by the Leon Medical Center staff for the member. The LMCHP UM Department utilizes standard criteria and other information as decided by the Chief Medical Officer of LMCHP or designee to make medical necessity determinations. This criteria is available to all providers upon request.

**Specialty Providers Referral/ Authorizations**

After the member has been treated by a specialist, their findings, diagnosis, and recommendations should be sent in writing to the member’s PCP for coordination of care and to be made a part of the member’s medical record. After the member has been seen by a specialist provider and that specialist requests additional medical services, the additional authorization requests will be processed in one of the following ways:

1. **Specialist is requesting an authorization for tests or procedures to be performed by him/her.** Unless previously approved, the specialist notifies the UM Department of the need for an authorization. The specialist will contact Leon Medical Centers Health Plans UM Department directly for an authorization. Leon Medical Centers Health Plans will review the request for approval for tests or procedures and notify the specialist.
2. **Specialist is requesting an authorization for tests or procedures not performed by him/her.** When any diagnostic services are recommended by the specialty provider, the specialty provider must contact the UM Department and request the authorization.

3. **Specialist is requesting a referral to another specialist provider.** If a referral to an additional specialist is recommended by the initial specialty provider, he/she should contact the member’s PCP for an additional referral approval request to the Leon Medical Centers Health Plans UM Department.

All additional referral/authorizations must have an authorization number from Leon Medical Centers Health Plans; lack of an authorization number for a specialty provider will result in the denial of a claim payment.

**Behavioral Health Referrals**

Leon Medical Centers Health Plans members can access their Behavioral Health Care benefits by contacting their PCP or directly calling PsychCare, the behavioral health provider for Leon Medical Centers Health Plans members. The PCP does not have to initiate a Referral /Authorization Request Form for these services. All behavioral health providers are required to obtain a signed consent from members so that information about important aspects of care, such as medication, can be forwarded to the PCP promptly. However, in order to obtain Psychotherapy services, Leon Medical Centers Health Plans members must obtain a referral from the Psychiatrist.

**Physical/Occupational/Speech Therapy Evaluations Authorizations**

The PCP/Participating Provider should request the initial evaluation/treatment of all outpatient therapy by using the Referral /Authorization Request Form. If further treatment is required, it is the responsibility of the therapy provider to obtain additional authorization from Leon Medical Centers Health Plans for continued treatment.

**Second Medical Opinions**

Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) are covered in accordance with Medicare’s second opinion rules and guidelines. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. For additional details on coverage rules, please refer to Medicare’s second opinion guidelines.

**Pended Referral /Authorization**

When a request for referral authorization for specialty services is received and the member’s eligibility status cannot be confirmed, the request is placed into a pended status until eligibility is either validated or determined invalid for date of service. The provider will be continuously updated as to the status of the pended request for authorization.
Referrals to Non-Participating Providers

The PCP or Specialist should first review the Leon Medical Centers Health Plans Provider Directory for the appropriate specialty provider. If one is not available within sixty (60) miles or thirty (30) minutes driving time from the member’s residence, then the PCP needs to identify an appropriate specialty provider to meet the member’s medical needs, complete the Request for Referral /Authorization Form and fax to the Leon Medical Centers Health Plans UM Department for review. In the event that a Leon Medical Centers Health Plans member receives non-emergent medical services from a non-participating specialty provider without an authorization number issued from the plan the member will be financially responsible for the medical services rendered.

Denial of Specialty Services Notification

All potential denials of medical service based on medical necessity will be reviewed and determined by the Leon Medical Centers Health Plans Chief Medical Officer or designee. The Chief Medical Officer or designee will make multiple attempts to contact the referring physician before the written final notice is mailed out. If the Chief Medical Officer or designee makes a denial determination as a result of the communication with the referring physician, then within three days of this verbal communication, Leon Medical Centers Health Plans will notify the referring physician and member of this adverse determination via a letter that includes the process for an expedited review and appeal of the adverse determination, if such is warranted.

Expedited Review for an Adverse Determination

Adverse determination means a coverage determination made by the Leon Medical Centers Health Plans Chief Medical Officer or designee that a request for authorization of medical services has been reviewed and based upon the information provided, does not meet the Leon Medical Centers Health Plans requirements for medical necessity, appropriateness, level of care or effectiveness. Authorization for the requested medical service is therefore denied.

If a member has an urgent appeal of an adverse determination and requests an expedited review, the Leon Medical Centers Health Plans Chief Medical Officer or designee will determine if criteria to expedite was met. This time frame shall not exceed seventy-two (72) hours. If it is determined not to be an urgent review, the member will be notified within twenty-four (24) hours of the decision not to expedite and in writing within 3 calendar days of telephonic notification. The member will also be notified that the adverse determination will be reviewed within the thirty (30) day Leon Medical Centers Health Plans appeal process. The PCP and/or specialty provider may also, acting on behalf of a member, request an appeal of an adverse determination of a utilization review decision. The PCP and/or specialist may call the Leon Medical Centers Health Plans UM Department, or the Grievance/ Appeal Coordinator and
request an expedited review of the UM denial decision made by the plan Chief Medical Officer or designee.

- An expedited review shall be evaluated by the appropriate clinical peer or peers. Leon Medical Centers Health Plans shall forward the expedited review request, within a time period not to exceed twenty-four (24) hours, to a clinical peer who can perform the expedited review.

- The clinical peer or peers shall not have been involved in the initial adverse determination.

- In an expedited review, all necessary information, including Leon Medical Centers Health Plans decision, shall be transmitted between Leon Medical Centers Health Plans and the member, or the provider acting on behalf of the member, by telephone, facsimile, or the most expeditious method available.

- In an expedited review, Leon Medical Centers Health Plans shall make a decision and notify the member, or the provider acting on behalf of the member, as expeditiously as the member’s medical condition requires, but in no event more than seventy-two (72) hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the member until the member has been notified of the determination.

- Leon Medical Centers Health Plans shall provide written confirmation of its decision concerning an expedited review within three (3) working days after providing notification of that decision.

- In any case when the expedited review process does not resolve a difference of opinion between Leon Medical Centers Health Plans and the member or the provider acting on behalf of the member, the health plan will forward a completed case file to the Independent Review Agency contracted by Medicare:

  MAXIMUS Federal Services
  Medicare Managed Care & PACE Reconsideration Project
  3750 Monroe Avenue
  Suite 702
  Pittsford, NY 14534-1302

**Prior Authorization:**
The following health care services always require Prior Authorization:
- All Outpatient Surgery/Procedures
- All Inpatient Admission
  - Hospital
  - LTAC
  - Rehabilitation
Skilled Nursing Facility
- Transfers between inpatient facilities
- AICD/ Wearable External Defibrillator Device (Elective or during the course of an inpatient stay)
- Durable Medical Equipment (DME)
- All Prosthetics and Orthotics, including repairs
- All Home Health Care
- High Tech Imaging, i.e. MRI/MRA, PET Scans, CT Scans outside LMC centers
- All requests for services to be performed by Non-Par facilities, physicians, or vendors

Leon Medical Centers Health Plans reserves the right to modify the prior authorization list as the utilization of new technologies develops or Medicare coverage determinations change.

**Information required for prior authorization includes but is not limited to:**
- Name, address, and Leon Medical Centers Health Plans ID number of the patient
- Name and telephone number of the admitting physician
- Diagnosis or reason for the health services
- Name and telephone number of the provider of the service
- Scheduled start date of service

The number of approved visits and length of authorization period are dependent upon the request, member’s benefits, medical appropriateness, and level of care. Authorization issued by Leon Medical Centers Health Plans will cover medically necessary service performed specific to the condition being treated and directly associated with the reason for the authorization.

To request Prior Authorization for a service or procedure, fax all relevant clinical information/office notes with completed form for review. If service requested is to occur in less than 2 business days please call the Utilization Management Dept. at:

☎ (305) 559-5366 or 1-866-393-5366  
Fax completed prior authorization forms to:  
(305) 642-1142  

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**EMERGENCY ROOM AND URGENT CARE ACCESS**

All emergency admissions must be authorized by Leon Medical Centers Health Plans within 24 hours, or the next business day of admission. Please be prepared to discuss the Member’s condition and treatment plan with our UM Staff.

Urgently needed care refers to a non-emergency situation where the member is inside the United States, the member is temporarily absent from the Plan’s authorized service area,
the member needs medical attention right away for an unforeseen illness, injury, or condition, and it isn’t reasonable given the situation for the member to obtain medical care through the Plan’s participating provider network. Note: Under unusual and extraordinary circumstances, care may be considered urgently needed when the member is in the service area, but the provider network of the Plan is temporarily unavailable or inaccessible. If a Member appears at an emergency room for care which is non-emergent, the Primary Care Physician should be contacted for direction.

### ON-SITE UM STAFF

Leon Medical Centers Health Plans provides a clinical staff to perform on-site review in many of our participating hospitals. The on-site staff will monitor the hospitalization of a member’s hospital stay and will work with the attending physician and hospital discharge planner to help coordinate care whether in an alternative care facility or in the home.

### DISCHARGE PLANNING

Discharge planning is an important function in the review process and may begin before the patient’s admission or early in the patient’s confinement. Discharge planning takes into account the specific medical requirements, the patient’s family and community support systems, and community practice patterns. The review staff also assists in the coordination of care between the physician, hospital discharge planner and any community provider (home health agency, DME company, etc.) required after the patient leaves the hospital.
SECTION XVI: RISK MANAGEMENT PROGRAM

I. OBJECTIVES

A. Overall Objective
   The objective of Leon Medical Centers Health Plans Risk Management Program is to promote effective quality patient care, while ensuring patient, visitor, employee, and physician safety by providing Leon Medical Centers Health Plans with the information necessary to carefully evaluate risks and exposures inherent in all the healthcare delivery system, and to allocate resources in the most efficient manner. s.641.55 (1)(a), F.S.

B. Specific Objectives
   The specific objectives of the Risk Management Program include the following:
   
   1. The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of healthcare providers and health care facilities to report injuries and incidents.
   
   2. The investigation and analysis of the frequency and causes of general categories and specific types of incidents.
   
   3. The development of appropriate measures to minimize the risk of injuries and incidents to patients, visitors, employees, and physicians.
   
   4. The analysis of patient grievances, which relate to patient care and quality of medical services.
   
   5. The prevention and reduction of claims, and reduction of resources required to meet legal obligations.
   
   6. The coordination of efforts designed to minimize risk to the patient, visitor, employee and physician.

II. RESPONSIBILITY OF THE PROGRAM

A. The Risk Management Program is the responsibility of the Governing Board of Leon Medical Centers Health Plans and is under the direct supervision of the Risk Manager who assures that the intent of the Risk Management Philosophy is carried out. s.641.55(2), F.S.

B. Every employee is oriented and instructed to take an active role in the prevention of injury to patients, visitors, employees and physicians and in the reporting of unusual occurrences to Risk Management. 59A-12.012(3), F.A.C.
III. PROGRAM ACTIVITIES

A. The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of Leon Medical Centers Health Plans, Inc. to report injuries and adverse incidents to the Risk Manager. s.641.55 (1)(d), F.S.

1. Incident reports shall be on a special form, and shall include at least the following information 59A-12.012(3), F.A.C. (see form sections)

   a. The patient’s name, address, age, sex, physical findings or diagnosis and, if hospitalized; locating information, admission time and date, and the facility’s name;

   b. a clear and concise description of the facts of the incident including time, date and exact location;

   c. a description of any injuries sustained;

   d. whether or not a physician was told and, if so, a brief statement of said physician’s recommendations for medical treatment, if any;

   e. a listing of all persons known to be involved in the incident, specifying functional title of each, including witnesses;

   f. the name, signature and position of the person completing the incident report form along with the date and time the report was completed.

2. If an adverse or untoward incident results in:

   a. the death of a patient or

   b. severe brain or spinal damage to a patient;

   c. a surgical procedure being performed on the wrong patient; or

   d. a surgical procedure unrelated to the patient’s diagnosis or medical needs being performed on any patient,

The organization must report this incident to the Agency of Health Care Administration and to the Department of Business and Professional Regulation within three (3) working days after its occurrence. A more detailed follow-up report must be submitted to the agency within ten (10) days after the first report. The agency may require an additional final report. s.641.55 (6), F.S.
The report shall be made on AHCA Form 3140-5001, Code 15 Report form. Any reportable incidents, pursuant to this section that are submitted more than 15 calendar days from occurrence by the organization must be justified in writing by the organization administrator. 59A-12.012(5)(d), F.A.C.

3. Information made known through the Quality Improvement Program which describes any potential or unusual occurrence which may cause or has caused injury to a patient, visitor, employee or physician will be reported to Risk Management on an Incident Report Form, by the person who is most familiar with the incident.

B. The investigation and analysis of the frequency and causes of general categories and specific types of incidents. The development of appropriate measures to minimize the risk of injuries and incidents to patients and visitors.

C. The analysis of patient grievances, which relate to patient care and quality of medical services. s.641.55 (1), F.S.

D. The prevention and reduction of claims, and reduction of resources required to meet legal obligations.

E. The coordination of efforts designed to minimize risk to the patient, visitor, employee and physician.
SECTION XVII: PROVIDER APPEAL PROCESS

Provider Appeal Process
As a provider you have 60 days or as outlined in your provider agreement from the date on the Explanation of Benefits (EOB) to appeal a claim decision. Providers have 2 levels of internal appeal. The 2nd level must also be requested within 60 days from the decision notice of the 1st appeal. To properly submit an appeal, the following items will be required:

- A Letter outlining the reason for the appeal
- Member Name
- Member Identification Number
- Date of Service
- Provider/Facility Name
- Supporting medical records
- Any additional information the provider/facility feels is necessary to appeal the decision

Please allow at least 60 days for the processing of claim or payment determination appeals.

The information should be sent to:

Leon Medical Centers Health Plans
Appeals Department
P.O. Box 66-9440
Miami, FL 33166
☎ FAX: 305-229-7500

Inpatient Appeal
Should a facility or provider disagree with an adverse determination while the Leon Medical Centers Health Plans member is still classified as inpatient, the provider may request an expedited appeal. This request may be in written or verbal form to Leon Medical Centers Health Plans. The case will then be reviewed by the Leon Medical Centers Health Plans’ Chief Medical Officer or designee. This could take up to 72 hours for resolution.
SECTION XVIII: PLAN BENEFIT SUMMARY

LEON MEDICAL CENTERS HEALTH PLANS – LEON CARES (HMO)

SUMMARY OF BENEFITS

IMPORTANT INFORMATION

If you have any questions about this plan’s benefits or costs, please contact Leon Medical Centers Health Plans for details.

<table>
<thead>
<tr>
<th>How much is the monthly premium?</th>
<th>$0 per month. In addition, you must keep paying your Medicare Part B premium.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much is the deductible?</td>
<td>This plan does not have a deductible.</td>
</tr>
<tr>
<td>Is there any limit on how much I will pay for my covered services?</td>
<td>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</td>
</tr>
<tr>
<td>Is there a limit on how much the plan will pay?</td>
<td>Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.</td>
</tr>
</tbody>
</table>

Leon Medical Centers Health Plans is an HMO plan with a Medicare contract. Enrollment in Leon Medical Centers Health Plans depends on contract renewal.

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE:
- SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.
- SERVICES WITH A ² MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.
# OUTPATIENT CARE AND SERVICES

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture and Other Alternative Therapies</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Ambulance</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing</td>
</tr>
</tbody>
</table>
| **Dental Services**<sup>2</sup>                        | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing Preventive dental services:  
  - Cleaning (for up to 2 every year): You pay nothing  
  - Dental x-ray(s) (for up to 2 every year): You pay nothing  
  - Fluoride treatment (for up to 2 every year): You pay nothing  
  - Oral exam (for up to 2 every year): You pay nothing  
  
  Our plan pays up to $3,000 every year for most dental services. |
| **Diabetes Supplies and Services**                     | Diabetes monitoring supplies: You pay nothing  
  Diabetes self-management training: You pay nothing  
  Therapeutic shoes or inserts: You pay nothing |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays**<sup>1,2</sup> | Diagnostic radiology services (such as MRIs, CT scans): You pay nothing  
  Diagnostic tests and procedures: You pay nothing  
  Lab services: You pay nothing  
  Outpatient x-rays: You pay nothing |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic radiology services (such as radiation treatment for cancer)</td>
<td>You pay nothing</td>
<td></td>
</tr>
<tr>
<td>Doctor's Office Visits&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician visit</td>
<td>You pay nothing</td>
<td></td>
</tr>
<tr>
<td>Specialist visit</td>
<td>You pay nothing</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (wheelchairs, oxygen, etc.)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>You pay nothing</td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>You pay nothing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You have unlimited worldwide coverage for medically necessary emergency and urgently needed services.</td>
<td></td>
</tr>
<tr>
<td>Foot Care (podiatry services)</td>
<td>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing</td>
<td></td>
</tr>
<tr>
<td>Home Health Care&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>You pay nothing</td>
<td></td>
</tr>
<tr>
<td>Mental Health Care&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Inpatient visit:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our plan covers 90 days for an inpatient hospital stay.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our plan also covers 60 &quot;lifetime reserve days.&quot; These are &quot;extra&quot; days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You pay nothing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient group therapy visit: You pay nothing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient individual therapy visit: You pay nothing</td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitation&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Coverage Details</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy visit</td>
<td><strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>Physical therapy and speech and language</td>
<td>visit: <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>therapy visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical therapy and speech and language</td>
<td>visit: <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>therapy visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Substance Abuse¹,²</td>
<td>Group therapy visit: <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual therapy visit: <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery¹,²</td>
<td>Ambulatory surgical center: <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient hospital: <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>Over-the-Counter Items</td>
<td>Please visit our website to see our list of covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>over-the-counter items.</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices (braces, artificial limbs,</td>
<td>Prosthetic devices: <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>etc.)¹</td>
<td>Related medical supplies: <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>Renal Dialysis¹,²</td>
<td><strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>Transportation¹</td>
<td><strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td><strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>You have unlimited worldwide coverage for medically</td>
<td></td>
</tr>
<tr>
<td></td>
<td>necessary emergency and urgently needed services.</td>
<td></td>
</tr>
<tr>
<td>Vision Services¹,²</td>
<td>Exam to diagnose and treat diseases and conditions of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the eye (including yearly glaucoma screening):</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routine eye exam (for up to 1 every year): **You</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pay nothing**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact lenses (for up to 1 every year): **You</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pay nothing**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our plan pays up to $140 every year for contact</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lenses.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eyeglasses (frames and lenses) (for up to 2 every</td>
<td></td>
</tr>
<tr>
<td></td>
<td>year): <strong>You pay nothing</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our plan pays up to $350 every year for eye glasses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(frames and lenses).</td>
<td></td>
</tr>
</tbody>
</table>
Eyeglasses or contact lenses after cataract surgery:
You pay nothing

$0 Copay for up to 2 pairs of eyeglasses each year
with value not to exceed $175 per pair of eyeglasses for a
total benefit value of $350.

Or

$0 copay for up to 4 boxes of contact lenses each year
with value not to exceed $35 per box of contact lenses for
a total benefit value of $140.

Available through network optical provider only.

Preventive Care¹,²

You pay nothing

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colonoscopy
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Fecal occult blood test
- Flexible sigmoidoscopy
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and
counseling
- Tobacco use cessation counseling (counseling for
people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots,
Pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit
Any additional preventive services approved by Medicare during the contract year will be covered.

### Hospice

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

### INPATIENT CARE

#### Inpatient Hospital Care

Our plan covers an unlimited number of days for an inpatient hospital stay.

- You pay nothing

#### Inpatient Mental Health Care

For inpatient mental health care, see the "Mental Health Care" section of this booklet.

#### Skilled Nursing Facility (SNF)

Our plan covers up to 100 days in a SNF.

You pay nothing

### PRESCRIPTION DRUG BENEFITS

#### How much do I pay?

For Part B drugs such as chemotherapy drugs:

- You pay nothing

Other Part B drugs: You pay nothing

#### Initial Coverage

You pay the following until your total yearly drug costs reach $10,000. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies.

#### Preferred Retail Cost-Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Generic)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Brand)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 3 (Specialty Tier)</td>
<td>33% of the cost</td>
<td>Not Offered</td>
</tr>
</tbody>
</table>
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what the plan has paid and what you have paid) reaches $10,000.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Drugs Covered</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Generic)</td>
<td>All</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

Preferred Retail Cost-Sharing


**Standard Retail Cost-Sharing**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Drugs Covered</th>
<th>One-month supply</th>
<th>Three-month supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Generic)</td>
<td>All</td>
<td>$5 copay</td>
<td>$15 copay</td>
</tr>
</tbody>
</table>

**Catastrophic Coverage**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the following:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Generic)</td>
<td>$2.65 copay or 5% of the cost (whichever costs more)</td>
</tr>
<tr>
<td>Tier 2 (Brand)</td>
<td>$6.60 copay or 5% of the cost (whichever costs more)</td>
</tr>
<tr>
<td>Tier 3 (Specialty Tier)</td>
<td>5% of the cost</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION ABOUT LEON MEDICAL CENTERS HEALTH PLANS – LEON CARES (HMO)**

**Description of Service**

**Dental Services**²

There are other benefit limitations. Please refer to the Dental Schedule of Benefits. Maximum yearly allowable is **$3,000.00 combined for Preventive and comprehensive benefit.**

The plan pays $3,000.00 towards all covered dental services.

**No Copayments for any service(s):**

1. Extraction, Erupted Tooth or Exposed tooth or forcep removal.
2. Amalgam
3. Root Canal
4. Denture Services*  
5. Resin
6. Crown - porcelain and ceramic substrate 1/year
7. Complete Denture 1/5 years
| Leon Healthy Living Centers | Access to the Leon Healthy Living Centers by Leon Medical Centers exclusive to Leon Medical Centers Health Plans’ members. 

Services include but are not limited to: 

- Fitness Center 
- Wellness Programs and Seminars 

Contact the plan for further details. |
| Over-the-Counter Items | Up to $25.00 per quarter for over-the-counter items which include vitamins and minerals for the exclusive use of enrollees. 

Available through Leon Medical Centers’ pharmacies only. 

The items covered by the benefit are limited to items that are consistent with CMS guidance in the most recent version of chapter 4 of the Medicare Managed Care Manual. 

The OTC enhanced benefit also includes delivery of the approved OTC items to our member’s home at no additional cost. |
| Transportation¹ | Transportation services are provided from the place of residence to the assigned center (determined by the geographic proximity) or to any LMC health plan provider and back to the place of residence. Transportation is unlimited. 

**Unlimited transportation by van** is covered to the Leon Healthy Living Centers for members who exclusively use the Leon Medical Centers transportation. |

*Must be enrolled in Leon Cares for a consecutive 90-days from the effective date of coverage to be eligible for dentures. 

Available through network dental provider only. |
All Cigna products and services are provided exclusively by or through such operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Arizona, Inc., HealthSpring Life & Health Insurance Company, Inc., HealthSpring of Tennessee, Inc., HealthSpring of Alabama, Inc., HealthSpring of Florida, Inc., Bravo Health Mid-Atlantic, Inc., and Bravo Health Pennsylvania, Inc. HealthSpring of Florida, Inc. operates under the assumed name of “Leon Medical Centers Health Plans” in the Miami-Dade service area. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. “Leon Medical Centers” is a registered trademark of Leon Medical Centers.
SECTION XIX: FORMS

- Medical Records Release
- Claims Inquiry Request
- Provider Appeal Request
- Grievance/Complaint Form
- Advance Directives
- Referral Form/Pre-Authorization
- Incident Report
MEDICAL RECORDS RELEASE

At Leon Medical Centers Health Plans, we believe in continuity of care. If you would like to have your medical records transferred in order to facilitate a smoother transition from your current health plan to Leon Medical Centers Health Plans, please complete the following information and return it to your current physician. This will enable the transfer of your records to your Leon Medical Centers Health Plans Primary Care Physician (PCP).

To: ______________________________________________________

Doctor or Hospital

_______________________________________________________

Address

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE

To: Dr. ______________________________________________________

Leon Medical Centers Health Plans Primary Care Physician

_______________________________________________________

Address

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM:

_______________________________ to __________________

Date Date

_______________________________

Patient's Name Patient or Nearest Relative

_______________________________

Address City, State & Zip Code

_______________________________

Witness Relation

Please make copies if additional forms are needed.
Claims Inquiry Request

Provider/Tax ID: ____________________________  Date: ________________
Provider Contact: ____________________________  Phone No.: __________

Claim Number: ________________________________
Member Name: ____________________________  ID#: ________________
Date Of Service: ________________________________
Billed Amount: ________________________________

Reason For Request:

_____ Claim not reimbursed at contracted rate.
    Underpaid by __________
    Overpaid by __________

_____ Referral/Authorization number __________ on file for dates of service(s).

_____ Corrected claim enclosed.

_____ Other: ___________________________________________________________

You may provide this information to us via fax (305) 642-1156 or mail back to:
Leon Medical Centers Health Plans
    Attn: Claims Dept.
    PO BOX 66-9441
    Miami, FL 33166
PROVIDER APPEAL REQUEST FORM

This form should be used if you disagree with the outcome of your claims inquiry or have additional information which may warrant Leon to re-evaluate its original decision. Appeal requests must include claim numbers and supporting documentation (ie: copies of medical records). Review of claims does not guarantee a change in payment. For Non-Participating providers: a Waiver of Liability is required when initiating an appeal. The Waiver of Liability form may be obtained at the following link: http://www.lmchealthplans.com/English/Forms/WaiverLiabilityStatement.pdf

Provider name ____________________________  Provider TIN____________________

Contact ___________________  Phone_____________  Fax _______________

Member Name ____________________________

Leon Member ID Number _________________

Member Address: ________________________________

Claim Number _________________

Date of Service _______________

Reason for Appeal:

________________________________________________________________________
________________________________________________________________________

Please mail this form attention to:

Leon Medical Centers Health Plans
Appeals Department
P.O. Box 66-9440
Miami, FL 33166

You can also fax your appeal request to (305)229-7500 or contact our department at (305)631-5348.

Physician’s Signature: ____________________________  Date: _______________

07/2016
GRIEVANCE/COMPLAINT FORM

Date: ________ Date of Birth: _________

Member’s Name: ____________________________________________

Member ID: ______________

Address: ______________ Phone: ______________

Summary of Grievance/ Complaint

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

Have you contacted the health plan regarding this matter? Yes   No (circle one)

If yes, what was the result of this contact?

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

What can we do to help you solve your problem?

________________________________________________________________________________________________________________________________________________________

Member’s Signature: ______________ Date: ____________

Please mail or fax this form and any other pertinent information to:
Leon Medical Centers Health Plans, Inc.
Grievance/Appeals Department
PO Box 66-9440
Miami, FL 33166
FAX: 305-229-7500
FORMULARIO DE QUEJA O DENUNCIA

Fecha: __________  Fecha de nacimiento: __________

Nombre del miembro: ____________________________________________

Número de identificación del miembro: ______________________________

Dirección: ___________________________ Teléfono: ________________
________________________________________________________________

Resumen de la queja o denuncia

________________________________________________________________

________________________________________________________________

________________________________________________________________

¿Se ha comunicado con el plan de seguro médico (plan de salud) en relación con este asunto? Sí  No (trace un círculo alrededor de la respuesta correspondiente)

Si respondió que sí, ¿en qué resultó dicha comunicación?

________________________________________________________________

________________________________________________________________

¿Qué podemos hacer para ayudarlo a resolver su problema?

________________________________________________________________

________________________________________________________________

________________________________________________________________

Firma del miembro: ___________________________  Fecha: __________

Favor de enviar este formulario y la demás información pertinente por correo o fax a:

Leon Medical Centers Health Plans, Inc.
Grievance/Appeals Department
PO Box 66-9440
Miami, FL 33166
FAX: 305-229-7500
Advance Directives

Leon Medical Centers Health Plans is an HMO plan with a Medicare contract. Enrollment in Leon Medical Centers Health Plans depends on contract renewal.

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This information is available for free in other languages. Please call our Member Services number at 305-559-5366 or toll-free at 1-866-393-5366 (TTY 711), seven days a week from 8:00 am to 8:00 pm. Esta información está disponible de forma gratuita en otros idiomas. Por favor, llame a nuestro Departamento
Leon Medical Centers Health Plans

Health Care Advance Directives

The Patient’s Right to Decide

Introduction
Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person’s decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes).

The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?
It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:
- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.
What is a living will?
It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?
It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

What is an anatomical donation?
It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver’s license or state identification card (at your nearest driver’s license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Which is best?
Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

Am I required to have an advance directive under Florida law?
No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?
No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?
Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.
Can I change my mind after I write an advance directive?
Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver’s license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver’s license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?
An advance directive completed in another state, as described in that state’s law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate and an alternate surrogate, be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
- Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.
- If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.
Additional Information Regarding Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

- As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

  If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.FloridaHealth.com or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.

  When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

- If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or www.med.ufl.edu/anatbd.

- If you would like to read more about organ and tissue donation to persons in need you can view the Agency for Health Care Administration’s website http://ahca.MyFlorida.com (Click on “Site Index,” then scroll down to “Organ Donors”) or the federal government site www.organdonor.gov. If you have further questions you may want to talk with your health care provider.

- Various organizations also make advance directive forms available. One such document is “Five Wishes” that includes a living will and a health care surrogate designation. “Five Wishes” gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:
Other resources include:

American Association of Retired Persons (AARP)
www.aarp.org
(Type “advance directives” in the website’s search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

Brochure: End of Life Issues
www.FloridaHealthFinder.gov (click Brochures and Guides)
(888) 419-3456
Living Will

Declaration made this _____ day of ________________, 2____, I, ____________________________, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and ______(initial) I have a terminal condition, or ______(initial) I have an end-stage condition, or ______(initial) I am in a persistent vegetative state, and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ____, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name ________________________________________________________
Street Address _________________________________________________
City _____________________ State _____________ Phone ____________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

(Signed) ________________________________________________________
Witness _____________________________ Witness _________________
Street Address ______________________ Street Address ______________________
City _____________________ State _______ City _____________________ State _______
Phone ___________________________ Phone __________________________

At least one witness must not be a husband or wife or a blood relative of the principal.
Definitions for terms on the Living Will form:

“End-stage condition” means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

“Persistent vegetative state” means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

“Terminal condition” means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statues. The Statutes can be found in your local library or online at www.leg.state.fl.us.
Designation of Health Care Surrogate

Name: ______________________________________________________

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name ______________________________________________________
Street Address _________________________________________________
City ________________________ State __________ Phone ____________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name ______________________________________________________
Street Address _________________________________________________
City ________________________ State __________ Phone ____________

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional):

_____________________________________________________________

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name ______________________________________________________
Name ______________________________________________________
Signed _____________________________________________________
Date _________________________

Witnesses:

1. ___________________________________
2. ____________________________________

At least one witness must not be a husband or wife or a blood relative of the principal.
Uniform Donor Form

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:

(a) _____ any needed organs or parts
(b) _____ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:

____________________________________________________________
____________________________________________________________

(c) _____ my body for anatomical study if needed. Limitations or special wishes, if any:

____________________________________________________________
____________________________________________________________

Signed by the donor and the following witnesses in the presence of each other:

Donor’s Signature ___________________________________
Donor’s Date of Birth _____________
Date Signed ______________
City and State _________________________________________
Witness _____________________________ Witness _____________________________
Street Address ________________________ Street Address ________________________
City _____________________ State ______ City _____________________ State ______

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver’s license or state identification card (at your nearest driver’s license office).
The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

Health Care Advance Directives

I, ____________________________________________________________,

have created the following Advance Directives:

☐ Living Will
☐ Health Care Surrogate Designation
☐ Anatomical Donation
☐ Other (specify)

Contact: ______________________________________________________

Name: _________________________________________________________

Address: _______________________________________________________

Telephone: ___________________________

Signature: ______________________________________________________

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308
1-888-419-3456
www.FloridaHealthFinder.gov
www.MyFloridaRx.com
http://ahca.myflorida.com
04-2006
**RE REFERRAL FORM**

Please be advised! Failure to comply with Utilization Management certification protocol will result in non-payment of your claim.

Appointment Date & Time ___________________________________________  Today’s Date ________________

**Patient Information**

| Patient's Name | ________ |
| ID Number | ________ |
| Patient's DOB | ________ |
| Patient's Group # | ________ |

**Primary Care Physician**

| PCP Name | ________ |
| Phone # | ________  Fax # ________ |
| Contact Name | ________  Provider # ________ |

**Complete this section when requesting specialty services**

| Provider Requested | ________  (print name/facility) |
| Specialty | ________ |
| Phone # | ________  Fax # ________ |
| Provider # | ________ |
| ☐ Consult & Recommendation Only. One visit within 60 days. |
| ☐ Consult & Diagnostic. Three visits within 90 days. |
| ☐ Consult/Treat/Diagnostic. Three visits within 90 days. |
| Services included in referral | ________ |

**Complete this section when requesting other referral services**

**REFERRAL FORM REMINDERS - PLEASE:**

- Include number of visits requested and level (blank requests are valid for 1 year only)
- Include patient ID number (blank referrals will be returned)
- Include provider signature (blank referrals will be returned)
- Give a copy of the referral to patients upon their request
- Authorization # will be issued within 72 hours

**Reason(s)/Indication(s) for referral**

| Previous TX/tests/procedures performed related to referral | ________ |

| PCP Signature | ________  Date | ________ |

**Referral Provider: Complete below or send appropriate consultation notes to PCP**

| Clinical Findings | ________ |
| Tests/Procedures Performed | ________ |
| TX Recommended | ________ |

| # of Additional Visits Requested | ________  Signature | ________  Date | ________ |

**SUBMIT REFERRALS TO:**

Leon Medical Centers, Att’n. Medical Management, 11501 SW 40th St. Miami, FL 33165

MEDICAL MANAGEMENT PHONE: (305) 642-5366, FAX: (305) 642-1658

WHITE - Patient's Chart  YELLOW - Specialist  PINK - LMC
**REFERRAL PRE-CERTIFICATION FORM**

To any avoid delay of this review, please submit any relevant documentation with this form (dictation, progress notes, consultation request and results).

- **Routine**
- **Medically Urgent**

**Today Date:** __/__/____

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Primary Care Physician</th>
<th>Referral to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:_______</td>
<td>PCP Name:_____________</td>
<td>Name:________________</td>
</tr>
<tr>
<td>ID Number:_________</td>
<td>Phone:_________________</td>
<td>Address:_____________</td>
</tr>
<tr>
<td>Patient DOB:_______</td>
<td>Fax:___________________</td>
<td>Phone #:_____________</td>
</tr>
<tr>
<td></td>
<td>Contact Name:_________</td>
<td>Fax:_________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contact Name:_______</td>
</tr>
</tbody>
</table>

**Services Requested - Please Attach Supporting Documentation**

- **Date of Service:** __/__/____
- **Facility Location:**

<table>
<thead>
<tr>
<th>Service Requested</th>
<th>Facility Location</th>
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</thead>
<tbody>
<tr>
<td>AMBULATORY SURGERY AND OUTPATIENT SURGERY</td>
<td></td>
</tr>
<tr>
<td>BONE SCAN</td>
<td></td>
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<tr>
<td>CARDIAC STRESS TEST</td>
<td></td>
</tr>
<tr>
<td>CHEMO THERAPY</td>
<td></td>
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<tr>
<td>CHRONIC CARE</td>
<td></td>
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<tr>
<td>CT SCAN OF:_________</td>
<td></td>
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<tr>
<td>DIALYSIS</td>
<td></td>
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<tr>
<td>DME</td>
<td></td>
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<tr>
<td>DOPPLER ARTERIAL</td>
<td></td>
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<tr>
<td>DOPPLER VENOUS</td>
<td></td>
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<tr>
<td>ECHOCARDIOGRAM</td>
<td></td>
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<tr>
<td>EEG</td>
<td></td>
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<tr>
<td>EKG</td>
<td></td>
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<tr>
<td>HOLTER</td>
<td></td>
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<tr>
<td>HOME HEALTH CARE</td>
<td></td>
</tr>
<tr>
<td>HOSPICE</td>
<td></td>
</tr>
<tr>
<td>INPATIENT ADMISSION (Including 23 hr Observation)</td>
<td></td>
</tr>
<tr>
<td>INVASIVE VASCULAR STUDIES/ED STUDIES</td>
<td></td>
</tr>
<tr>
<td>IVPS</td>
<td></td>
</tr>
<tr>
<td>MAMMOMGRAM</td>
<td></td>
</tr>
<tr>
<td>MRA</td>
<td></td>
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<tr>
<td>MRI OF:_________</td>
<td></td>
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<tr>
<td>NUCLEAR MEDICINE</td>
<td></td>
</tr>
<tr>
<td>OCCUPATIONAL THERAPY</td>
<td></td>
</tr>
<tr>
<td>OUT OF AREA OR NON PARTICIPATING PROVIDER</td>
<td></td>
</tr>
<tr>
<td>PHYSICAL THERAPY</td>
<td></td>
</tr>
<tr>
<td>PLASTIC AND RECONSTRUCTIVE THERAPY</td>
<td></td>
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<tr>
<td>PROSTHETIC/ ORTHOTIC DEVICES</td>
<td></td>
</tr>
<tr>
<td>PULMONARY FUNCTION TEST</td>
<td></td>
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<tr>
<td>PULMONARY REHABILITATION</td>
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<tr>
<td>RADIATION TREATMENT</td>
<td></td>
</tr>
<tr>
<td>RENAL SONOGRAM</td>
<td></td>
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<tr>
<td>SKILLED NURSING/REHABILITATION FACILITY</td>
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<tr>
<td>SLEEP STUDY</td>
<td></td>
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<tr>
<td>SONOGRAM</td>
<td></td>
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<tr>
<td>SPEECH THERAPY</td>
<td></td>
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<tr>
<td>STRESS THALLIUM</td>
<td></td>
</tr>
<tr>
<td>TRANSFUSION/ INFUSION</td>
<td></td>
</tr>
<tr>
<td>OTHER:_____________</td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Information (ICD 9 Code and CPT Codes Must Be Completed)**

**CONSULTATION - ONE VISIT WITHIN 60 DAYS**

<table>
<thead>
<tr>
<th>Primary Diagnosis:</th>
<th>ICD-9 Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified TX/Procedures:</td>
<td>CPT - Code:</td>
</tr>
</tbody>
</table>

**Initial Findings:**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

**Provider Signature:** ___________________________  **Date:** __/__/____

**PLEASE SUBMIT CLAIMS TO:** Leon Medical Centers Health Plans Inc., Attention Claims Department, PO Box 65-9006, Miami Fl. 33265

**REFERRAL/AUTHORIZATION IS FOR ALL CONSULTATION TO CONTRACTED PROVIDERS OF THE PLANS AS SPECIFIED HEREIN ONLY AND IS A GUARANTEE OF CLAIMS PAYMENT UNLESS ALL NECESSARY AUTHORIZATION PROCEDURES ARE FOLLOWED COMPLETE AND AUTHORIZATION IS RECEIVED FOR COVERED SERVICE FOR AN ELEGIBLE MEMBER.**
# Incident Report

## Incident Report #:

<table>
<thead>
<tr>
<th>NAME:</th>
<th>AGE</th>
<th>DOB</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID#:</td>
<td>SEX</td>
<td>Attending MD:</td>
<td></td>
</tr>
<tr>
<td>Contact #:</td>
<td>OCCURRENCE DATE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission DX:</td>
<td>OCCURRENCE TIME:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report by: (Print)</td>
<td>FACILITY:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Category/Code:

<table>
<thead>
<tr>
<th>Category/Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## INCIDENT FACTS

### DESCRIPTION OF INJURY/INCIDENT

ICD-9 and /or CPT Codes: ____________________________________________________________________________

NAMES OF PERSONS PRESENT (including employees):

______________________________________________________________________________________________

______________________________________________________________________________________________

## MEDICAL

WAS PERSON INVOLVED EXAMINED BY A PHYSICIAN?  □ Yes  □ No  Date: ___/___/___  Time: __

EXAMINING PHYSICIANS NAME: ___________________________  LOCATION: ___________________________

PHYSICIAN'S COMMENT: _____________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Physician’s Signature ___________________________  Date __________/_______/_______  Time __________

X-Ray Ordered  □ Yes  □ No  X-Ray Results: _____________________________

Lab Ordered  □ Yes  □ No  Lab Results: _____________________________

Signature of Person Preparing Report  ________________  Title  __________________  Date & Time  __________________
Complaint/Grievance Related:
______________________________________________________________

Risk Manager Review:
Received by:________________ Date: ___/___/___ Time: _____AM/PM

Findings:
_________________________________________________________________
_________________________________________________________________

Medical Director Review:
_________________________________________________________________
_________________________________________________________________

Medical Director’s Signature: ___________________________ Date: ___/___/___

RM Activity:
Level: □ 1: □ 2: □ 3: □ 4: □ 5:

□ Legal Department  □ Medical Director/Peer Review
□ Log/Trend  □ Education  □ Other:______________________________

Final Outcome: ___________________________ Closure Date: ___/___/___

Risk Manager’s Signature: ___________________________ Date: ___/___/___
## Categories

<table>
<thead>
<tr>
<th>Code</th>
<th>Severity of Injury Scale</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Injury</td>
<td>Lost, stolen or damaged property. Fright, no physical damage.</td>
</tr>
<tr>
<td>00</td>
<td>Property</td>
<td>Fright, no physical damage.</td>
</tr>
<tr>
<td>1</td>
<td>Emotional only</td>
<td>Lacerations, contusions minor scars, rash. No delay. Non-displaced fracture.</td>
</tr>
<tr>
<td>2</td>
<td>Insignificant</td>
<td>Infections, missed fracture, fall. Recovery, delayed.</td>
</tr>
<tr>
<td>3</td>
<td>Minor</td>
<td>Burns, surgical material left, drug side effect, brain damage. Recovery delayed.</td>
</tr>
<tr>
<td>4</td>
<td>Major</td>
<td>Loss of fingers, loss or damage to organs. Includes non-disabling injuries.</td>
</tr>
<tr>
<td>5</td>
<td>Permanent</td>
<td>Deafness, loss of limb, loss of eye, loss of kidney etc.</td>
</tr>
<tr>
<td>6</td>
<td>Significant</td>
<td>Paraplegia, blindness, loss of two limbs, brain damage.</td>
</tr>
<tr>
<td>7</td>
<td>Major</td>
<td>Quadriplegia, severe brain damage, lifelong care or fatal prognosis.</td>
</tr>
<tr>
<td>8</td>
<td>Grave</td>
<td>Level 1 = No quality problem identified</td>
</tr>
<tr>
<td>9</td>
<td>Death</td>
<td>Level 2 = Potential quality problem w/minimal significance</td>
</tr>
<tr>
<td>10</td>
<td>Unknown</td>
<td>Level 3 = Confirmed quality problem w/minimal significance</td>
</tr>
</tbody>
</table>

- **Level 1**: No quality problem identified
- **Level 2**: Potential quality problem w/minimal significance
- **Level 3**: Confirmed quality problem w/minimal significance
- **Level 4**: Confirmed quality problem w/moderate significance
Level 5 = Confirmed quality problem w/major significance
SECTION XIX: ADDITIONAL MEDICARE ADVANTAGE TERMS AND CONDITIONS OF PARTICIPATION AND ACCREDITATION REQUIREMENTS

TERMS AND CONDITIONS OF PARTICIPATION

DISCRIMINATION PROHIBITED
Provider shall not deny, limit, or condition the furnishing of benefits to a Member on the basis of any factor that is related to health status, including, but not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability. [42 C.F.R. § 422.110(a).]

EMERGENCY SERVICES
Leon Medical Centers Health Plans shall pay for Covered Services that are emergency services rendered to a Member to treat an emergency medical condition or for which Leon Medical Centers Health Plans instructed the Member to seek treatment within or outside the service area or Leon Medical Centers Health Plans’ provider network.

URGENTLY NEEDED SERVICES
Leon Medical Centers Health Plans shall pay for all Covered Services constituting Urgently Needed Services rendered to a Member. [42 C.F.R. § 422.100(b); 42 C.F.R. § 422.112(a)(9).]

RENAL DIALYSIS SERVICES
Leon Medical Centers Health Plans shall pay for all Covered Services constituting renal dialysis services provided to a Member while the Member was temporarily outside the service area. [42 C.F.R. § 422.100(b)(iv).]

PROVIDER NETWORK
Leon Medical Centers Health Plans will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. [42 C.F.R. § 422.112(a)(1).]

SPECIALTY CARE
Leon Medical Centers Health Plans will provide or arrange for necessary specialty care, and in particular give female Members the option of direct access to a women’s health specialist within the network for women’s routine and preventive health care services provided as basic benefits (as defined in 42 C.F.R. § 422.2). Furthermore, Leon Medical Centers Health Plans will arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a Member’s medical needs. [42 C.F.R. § 422.112(a)(3).]

ACCESSIBILITY OF SERVICES
Provider’s hours of operation must be convenient to the population served and shall not be designed to discriminate against Leon Medical Centers Health Plans Members. Leon Medical Centers Health Plans must ensure that services are available to Members 24 hours a day, 7 days a week, when medically necessary... [42 C.F.R. § 422.112(a)(7).]
PROVIDER TERMINATION AND/OR SUSPENSION
Leon Medical Centers Health Plans may at times terminate or suspend agreements with participating providers. Termination may be based on a change in business needs, provider breach of contract terms, or other reasons which may necessitate contract termination. Terminations will be handled in compliance with law and contractual obligations. [42 C.F.R. § 422.204.]

MAINTENANCE AND CONFIDENTIALITY OF RECORDS
For any medical records or other information Provider maintains with respect to Members, Provider must establish procedures to: (a) safeguard the privacy of any information that identifies a Member; (b) release information from, or copies of, records only to authorized individuals; (c) ensure that unauthorized individuals cannot gain access to or alter Member records; (d) release original medical records only in accordance with Federal and State laws, court orders, or subpoenas; (e) maintain the records and information in an accurate and timely manner; (f) ensure timely access by Members to the records and information that pertain to them; and (g) abide by all state and federal laws regarding confidentiality and disclosure for mental health records, medical records, other health information and Member information. [42 C.F.R. § 422.118.]

MARKETING
Provider acknowledges and agrees that all marketing activities related to a Benefit Program must conform to the requirements of the Medicare Advantage Program, codified at 42 C.F.R. § 422.80, as amended from time to time. Provider and Leon Medical Centers Health Plans will not engage in any such marketing activities related to their contractual obligations, directly or indirectly, without first obtaining CMS approval. [42 C.F.R. § 422.80.]

PROVISION OF SERVICES
Provider agrees to provide Covered Services in a manner consistent with professionally recognized standards of health care and further to (a) provide Covered Services in a culturally competent manner to all Members by making a particular effort to ensure that those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled; (b) provide Members information regarding treatment options in a culturally competent manner, including the option of no treatment; and (c) ensure that Members with disabilities have effective communications with representatives of Facility in making decisions regarding treatment options. [42 C.F.R. § 422.112(a)(8).] Leon Medical Centers Health Plans and Provider will work together to ensure that (i) an initial assessment of each enrollee's health care needs, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment; (ii) Provider maintains an enrollee health record in accordance with professional standards of health care and Leon Medical Centers Health Plans policies and procedures; and (iii) there is appropriate and confidential exchange of information among all Providers in order to maintain continuity of care for Leon Medical Centers Health Plans enrollees. [42 C.F.R. § 422.112(b)(4).] Provider will deliver all Covered Services in a manner consistent with professionally recognized standards of health care. [42 C.F.R. § 422.504(a)(3)(iii).]
ADVANCE DIRECTIVES
Provider must document in a prominent part of the individual’s current medical record whether or not the individual has executed an advance directive. [42 C.F.R. § 422.112(b)(4).]

CONTRACT REQUIREMENTS BETWEEN PROVIDER AND LEON MEDICAL CENTERS HEALTH PLANS
Provider acknowledges that payment and incentive arrangements between Leon Medical Centers Health Plans, providers, first tier, & downstream entities must be specified in all contract(s). [42 C.F.R. § 422.504.]

COMPLIANCE WITH LAW
Leon Medical Centers Health Plans and Provider agree to comply with federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.), and the anti-kickback statute (section 1128B(b)) of the Act; and (2) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. [42 C.F.R. § 422.504(h).]

DISCLOSURE TO MEMBERS
Leon Medical Centers Health Plans and Provider agree to comply with the requirements of 42 C.F.R. § 422.411 regarding disclosure of certain prescribed information to Members. [42 C.F.R. § 422.504(a)(4).]

SUBMISSION OF INFORMATION TO CMS
Provider agrees to assist Leon Medical Centers Health Plans in submitting to CMS, all information that is necessary for CMS to administer and evaluate Leon Medical Centers Health Plans’ benefit programs and to simultaneously establish and to assist Leon Medical Centers Health Plans in facilitating a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to the information prescribed in 42 C.F.R. § 422.504(f)(2). [42 C.F.R. § 422.504(f)(2).]

NOTIFICATION OF MEMBERS
Provider acknowledges and agrees to assist Leon Medical Centers Health Plans in making a good faith effort to notify all affected Members of the termination of a provider contract within 30 days of notice of termination by Leon Medical Centers Health Plans or Provider. [42 C.F.R. § 422.111(e).]

COMPLETENESS AND TRUTHFULNESS OF DATA SUBMITTED TO CMS
Provider and Leon Medical Centers Health Plans agree to comply with the reporting requirements in 42 C.F.R. § 422.516 and the requirements in 42 C.F.R. § 422.310 for submitting data to CMS. [42 C.F.R. § 422.504(a)(8)]. Provider agrees to certify that all data submitted to Leon Medical Centers Health Plans and/or CMS pursuant to the foregoing provisions is or will be complete and truthful as required by 42 C.F.R. § 422.504(l)(3).

CONTRACT REQUIREMENTS AND RECORDS MAINTENANCE REQUIREMENTS
Provider and Leon Medical Centers Health Plans understand and agree that the requirements of 42 C.F.R. § 422.504(i)(3)-(4) must be contained in the agreement specifying the relationship between Provider and Leon Medical Centers Health Plans. Additionally, Leon Medical Centers Health Plans agrees to comply with the prompt payment provisions of 42 C.F.R. § 422.520 and
with instructions issued by CMS. Furthermore, Provider and Leon Medical Centers Health Plans agree to maintain for 10 years books, medical records, documents, and other evidence of procedures and practices that are sufficient to enable CMS to audit, evaluate, or inspect such books, contracts, medical records, patient care documentation, and other records that pertain to any aspect of services performed for Medicare Advantage, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract. [42 C.F.R. § 422.504(d)-(e).]

QUALITY AND MEDICAL MANAGEMENT
Provider agrees to comply with Leon Medical Centers Health Plans’ medical, quality and medical management policies as required by CMS. Provider further agrees to consult with Leon Medical Centers Health Plans in the development of such policies. [42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5).]

DISCLOSURES TO CMS REGARDING QUALITY AND PERFORMANCE INDICATORS
Leon Medical Centers Health Plans agrees to disclose to CMS quality & performance indicators for plan benefits including those regarding disenrollment rates for Members enrolled over the previous two years; enrollee satisfaction; and health outcomes. [42 C.F.R. § 422.504(f)(2)(iv)(A) – (C).]

DENIAL, SUSPENSION AND TERMINATION OF PROVIDER
Leon Medical Centers Health Plans agrees to notify Provider in writing of reasons for denial, suspension & termination. [42 C.F.R. § 422.204(c)(1).] Furthermore, Leon Medical Centers Health Plans and Provider agree to provide at least 90 days notice (terminating contract without cause) [42 C.F.R. § 422.204(c)(4).]

CIVIL RIGHTS, ADA, AGE DISCRIMINATION AND FEDERAL FUNDS LAWS
Provider and Leon Medical Centers Health Plans agree to comply with Civil Rights Act, ADA, Age Discrimination Act, federal funds laws. [42 C.F.R. § 422.504(h)(1).]

PROHIBITION ON EMPLOYMENT OR CONTRACTING WITH EXCLUDED INDIVIDUALS
Leon Medical Centers Health Plans and Provider acknowledge and agree that they are prohibited from employing or contracting with individuals excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act. [42 C.F.R. § 422.752(a)(8).]

APPEALS AND GRIEVANCE PROCEDURES
Provider agrees to adhere to Leon Medical Centers Health Plans’ appeals and grievance procedures as set forth in this document. [42 C.F.R. § 422.562(a)
ACCREDITATION REQUIREMENTS

Leon Medical Centers Health Plans is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) and therefore is providing additional information to all of our participating providers in order to assure compliance with all applicable standards of our accrediting agency.

**Member Rights as it relates to AAAHC**  (Refer to section “Rights and Responsibilities” in the provider manual for a full description of Member’s Rights and Responsibilities)

Patients are treated with respect, consideration and dignity.

Patients are provided appropriate privacy.

Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law.

Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

Information is available to patients and staff concerning:

1. Patient rights, including those specified above
2. Patient conduct and responsibilities
3. Services available at the organization
4. Provisions for after-hours and emergency care
5. Fees for services
6. Payment policies
7. Patient’s right to refuse to participate in experimental research
8. Advance directives, as required by state or federal law and regulations
9. The credentials of health care professionals

Prior to receiving care, patients are informed of patient responsibilities. These responsibilities require the patient to:

1. Provide complete and accurate information to the best of his/her ability about his/her health, any allergies or sensitivities
2. Follow the treatment plan prescribed by his/her provider
3. Provide a responsible adult to transport him/her home from the facility and remain with him/her for twenty-four (24) hours, if required by his/her provider
4. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care
5. Accept personal financial responsibility for any charges not covered by his/her insurance
6. Be respectful of all the health care providers and staff, as well as other patients

Patients are informed of their right to change their provider if other qualified providers are available.

Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.

Patients are informed about procedures for expressing suggestions, complaints and grievances, including those required by state and federal regulations.

**Credentialing**

Medical staff must apply for reappointment every three (3) years; or more frequently if federal and/or state law or organizational policies so stipulate. At reappointment, the organization requires completion of a reappointment application and provides the following documentation:

- Continuity, relevance and documentation of any interruptions in their experience
- Current state license
- Drug Enforcement Administration (DEA), if applicable
- Proof of current medical liability coverage (if elected to not carry malpractice insurance, provider must have notification of such posted in office)

The scope of procedures will be reviewed and amended as appropriately determined by the Credentialing Committee.

On an ongoing basis, the provider must submit time sensitive documentation to the plan. Some of the documents include, but are not limited to, the following:

- State license
- DEA
- Malpractice Insurance

**Quality of Care Provided**

All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.

Health care professionals practice their professions in an ethical and legal manner.

All personnel assisting in the provision of health care services are appropriately trained, qualified and supervised are available in sufficient numbers for the care provided.
The organization facilitates the provision of high-quality health care as demonstrated by the following:

1. Health care provided is consistent with current professional knowledge.
2. Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system.
3. Appropriate and timely diagnosis based on findings of the current history and physical examination.
4. Review and update of all individual patient medications at each visit, including over-the-counter products and dietary supplements when information is available.
5. Treatment that is consistent with clinical impression or working diagnosis.
6. Appropriate and timely consultation.
7. Absence of clinically unnecessary diagnostic or therapeutic procedures.
8. Appropriate and timely referrals.
9. Appropriate and timely follow-up of findings and tests.
10. Patient cooperation.
11. Continuity of care and patient follow-up.

The organization provides for accessible and available health services and ensures patient safety by at least the following:

1. Provision for and information about services when the organization’s facilities are not open.
2. Adequate and timely transfer of information when patients are transferred to other health care professionals.
3. An increased likelihood of desired health outcomes through participation in performance measurement and quality improvement activities.

The organization maintains appropriate, accurate and complete and timely clinical record entries.

The organization establishes procedures to obtain, identify, store and transport laboratory specimens or biological products.

When clinically indicated, patients are contacted as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings that have been identified.

When the need arises, patients are transferred from the care of one health care professional to the care of another with:

1. Adequate specialty consultation services being available by prior arrangement.
2. Referral to a health care professional that is clearly outlined to the patient and arranged with the accepting health care professional prior to transfer.

When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.

**Clinical Records and Health Information**
The organization develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval and distribution for patient records. An additional clinical record is established for each person receiving care. Each record includes, but it is not limited to:

1. Name
2. Identification number (if appropriate)
3. Date of birth
4. Gender

Responsible party, if applicable

All clinical information relevant to a patient is ready available to authorized health care practitioners any time the organization is open to patients.

Except when otherwise required by law, any record that contains clinical, social, financial or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

A designated person is in charge of clinical records. This person’s responsibilities include, but are not limited to:

1. The confidentiality, security and physical safety of records
2. The timely retrieval of individual records upon request
3. The unique identification of each patient’s record
4. The supervision of the collection, processing, maintenance, storage, retrieval and distribution of records

The maintenance of predetermined, organized and secured records format

Policies concerning clinical records address, but are not limited to:

1. The retention of active records
2. The retirement of inactive records
3. The timely entry of data in records

The release of information contained in records.

Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.

Reports, histories and physicals, progress notes and other patient information (such as laboratory reports, x-ray reading, operative reports, and consultations) are reviewed and incorporated into the record in a timely manner.

If a patient has had multiple visits/admission, or the clinical record is complex and lengthy, a summary of past and current diagnosis or problems, including past procedures, is documented in that patient’s record to facilitate the continuity of care.
The presence of absence of allergies and untoward reactions to drugs and materials is records in a prominent and uniform location in all patient records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are located.

Entries in a patient’s record for each visit include, but are not limited to:
1. Date, department (if departmentalized), and physician or other health care professional’s name and credential (for example, PT, RN, CRNA)
2. Chief complaint or purpose of visit
3. Clinical findings
4. Discharge diagnosis or impression
5. Studies ordered, such as laboratory or x-ray studies
6. Care rendered and therapies administered
7. Any changes in prescription and non-prescription medication with name and dosage, when available
8. Disposition, recommendations and instructions given to the patient
9. Authentication and verification of contents by health care professionals

Documentation regarding missed and cancelled appointments.

Significant medical advice given to a patient by telephone is entered in the patient’s record and appropriately signed or initiated, including medical advice provided by after-hours telephone patient information or triage telephone services.

Clinical record entries are legible and easily accessible within the record by the organization’s personnel.

Any notation in the patient’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.

The organization is responsible for ensuring a patient’s continuity of care. If a patient’s primary or specialty care provider(s) of health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of patient care are:
1. Obtained from the other (external) provider(s) or organization and incorporated into the patient’s clinical record

Provided to the other (external) health care professional(s) or consultant and, as appropriate, to the organization where future care will be provided.

Discussions with the patient concerning the necessity, appropriateness and risks of proposed care, surgery or procedure, as well as discussions of treatment alternatives and advance directives, as applicable, are incorporated into the patient’s medical record.