Provider Handbook

2013-14 Supplement for First Coast Advantage, LLC.
A Florida Medicaid PSN
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I. INTRODUCTION

Welcome to the ValueOptions® Florida Provider Handbook Supplement for Florida Medicaid and First Coast Advantage, LLC. Provider Service Network (FCA, LLC.). As a ValueOptions® Florida Medicaid Network Provider, you join some of the most accomplished behavioral health care facilities and professionals in the state – people who share our commitment to making quality mental health care more accessible.

This handbook has been developed as a supplement to the ValueOptions® National Provider Handbook, in order to address behavioral health policies and procedures specific to FCA, LLC.. It is to be used in conjunction with the ValueOptions® Florida National Handbook.

If you have any questions or comments while reading the handbook, or at any time, please call us on our toll-free Information Line at (855) 627-0390.

If at any time, this supplement conflicts with the ValueOptions® Florida National Handbook, this supplement will prevail.

Thank you for your participation in our network. We look forward to a long and rewarding relationship with you as we work together to provide quality member care.

II. HOW PROVIDERS OBTAIN ASSISTANCE

For authorization requests, eligibility verification claims submission and status please access the ProviderConnectSM online portal located on the ValueOptions® Florida website at:

https://www.ValueOptions.com/pc/eProvider/providerLogin.do

You can also reach us by calling (855) 627-0390 or by fax at (813) 246-7216.

We are here to assist by phone 24 hours a day, seven days a week for:

- Preauthorization for clinical services
- Utilization review for continued stay
- Crisis counseling and assistance
**Member and Provider Information:** Representatives are available from 7:00 a.m. to 6:00 p.m. (EST), Monday through Friday for:

- Verification of Medicaid Eligibility
- Verification of Member’s Authorization
- Verification of Medicaid Eligibility
- Claims Inquiries
- Written Inquiries
- Benefit Explanations
- Prevention, Education and Outreach Referral Information
- Provider relations/education
- Credentialing and recredentialing questions

**III. COVERED BENEFITS**

ValueOptions® Florida, Inc. manages the provision of medically necessary covered behavioral health services, pursuant to the Florida State Medicaid Plan and in accordance with the Florida Medicaid Hospital Services Handbook, Community Behavioral Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Handbook for the First Coast Advantage, LLC. Network.

The following table lists the general service categories that are covered by ValueOptions® Florida Medicaid and those that are not covered.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inpatient hospital services*</td>
<td>Inpatient hospital services for psychiatric conditions with the following ICD-9-CM: 290-290.43, 290.8, 290.9, 293.0-298.9, 300-301.9, 302.7, 306.51-312.4 and 312.81-314.9, 315.3, 315.31, 315.5, 315.8 and 315.9</td>
</tr>
<tr>
<td>* 45 day FY CAP applies to child/adolescent and adult inpatient hospital services</td>
<td></td>
</tr>
<tr>
<td>B. Psychiatric Physician Services</td>
<td>Applicable to specialty codes 42, 43 and 44; for psychiatric conditions with the following ICD-9-CM: 290-290.43, 290.8, 290.9, 293.0-298.9, 300-301.9, 302.7, 306.51-312.4 and 312.81-314.9, 315.3, 315.31, 315.5, 315.8 and 315.9</td>
</tr>
</tbody>
</table>
### C. Outpatient hospital services
1. emergency room*
2. observation
3. psychiatric clinic
4. psychiatric electroshock treatment*
5. psychiatric visit/individual therapy
6. psychiatric/testing

* $1,500 combined FY CAP applies to the above outpatient services with the exception of Electroshock Treatment (Revenue Code 0901); Emergency Room Services (Revenue Code 0450, 0451); Intensive Outpatient Treatment (Revenue Code 0905); Outpatient Group and Family Therapy (Revenue Code 0915 and 0916)

### Outpatient hospital services for psychiatric conditions with the following ICD-9-CM: 290-290.43, 290.8, 290.9, 293.0-298.9, 300-301.9, 302.7, 306.51-312.4 and 312.81-314.9, 315.3, 315.31, 315.5, 315.8 and 315.9

### D. Community Mental Health Services


### E. Mental health Targeted Case Management

Children: T1017HA and Adults: T1017

### F. Mental Health Intensive Targeted Case Management

Adults: T1017HK

### G. Community Substance Abuse Services

*when the appropriate ICD-9 CM diagnosis code 290 through 290.43, 293.0 through 298.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, and 315.9) has been documented

H0001; H0001HN; H0001HO; H0001TS; H0047; H2010HF; H2012HF; T1007; T1007TS; T1015FH or T1023HF

### H. Inpatient Hospital Substance Abuse for Pregnant enrollees

0116, 0136, 0156

### I. Telepsychiatry/Telebehavioral Health

T1015GT, H2019HRGT
Non-Covered Services

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialized therapeutic foster care</td>
</tr>
<tr>
<td>Therapeutic group care services</td>
</tr>
<tr>
<td>Behavioral health overlay services</td>
</tr>
<tr>
<td>Community substance abuse services –except for those listed as a covered service indicated above</td>
</tr>
<tr>
<td>Residential care services</td>
</tr>
<tr>
<td>Statewide inpatient psychiatric program (SIPP) services</td>
</tr>
<tr>
<td>Clubhouse services</td>
</tr>
<tr>
<td>Comprehensive behavioral health assessment</td>
</tr>
<tr>
<td>Behavioral health services to members assigned to FACT team by SAMH office</td>
</tr>
<tr>
<td>Behavioral health services to members enrolled in CWPMHP*</td>
</tr>
</tbody>
</table>

Some services may be available through the Medicaid program but not covered under the provider agreement. Those services will be reimbursed directly through the Medicaid fee-for-service program. ValueOptions® Florida will assist in determining if the service is medically necessary and the case coordination of such services.

IV. ACCESS TO CARE

Provider Responsibilities

ValueOptions® Florida, Inc. in conjunction with Florida Medicaid and First Coast Advantage, LLC. require specific access standards that must be met regardless of the provider’s contracting arrangement. Members must have timely access to appropriate mental and behavioral health services from all providers, 24 hours a day, 7 days per week. Providers must comply with the following standards:

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care*</td>
<td>Immediately</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 1 day</td>
</tr>
<tr>
<td></td>
<td>*Please note that individuals discharged from jail or DJJ must be seen within urgent care timeframe.</td>
</tr>
<tr>
<td>Routine care</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td>Crisis Stabilization Units discharge follow-up</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td>Continuing services after initial clinical appointment</td>
<td>The next schedule appointment must be within 14 calendar days of the initial- with the most appropriate clinician (including MD), and then as per the treatment plan or the member’s clinical condition.</td>
</tr>
</tbody>
</table>
Non-Emergent Out-Of-Network Services: Providers must contact ValueOptions® Florida for prior authorization non-emergent out-of-network services at (855) 627-0390

Emergency Care: Prior Authorization is not required for Emergency Services. Providers are requested to notify ValueOptions® Florida within 24 hours of determining that the member has behavioral health coverage through First Coast Advantage, LLC. When the provider identifies the emergency status, ValueOptions® Florida will gather minimal clinical data to register the event and will seek additional concurrent review data after 48 hours. ValueOptions® Florida will not deny covered behavioral health emergency services.

The attending physician or the provider actually treating the member is responsible for determining when a member is sufficiently stabilized for transfer or discharge. This decision is binding for emergency admissions but does not apply to non-emergent admissions.

Additional Provider Responsibilities - Access to Care

- Provide access to services twenty-four (24) hours a day, seven days a week.
- Provide coverage for your practice when you are not available, including, but not limited to, an answering service with emergency contact information.
- Respond to telephone messages in a timely manner.
- Contact ValueOptions® Florida immediately if member does not show for an appointment following an inpatient discharge so that ValueOptions® Florida can conduct appropriate follow-up.
- Contact ValueOptions® Florida immediately if you are unable to see the member within the required timeframes.
- Comply with AHCA’s “Appointment Waiting Times.”

ValueOptions® Florida Responsibilities:
In order to promote timely access to care for our members, ValueOptions® Florida utilizes the following guidelines for processing service requests:
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited Service Requests</td>
<td>One (1) business day of receipt of a complete request</td>
</tr>
<tr>
<td>Concurrent Inpatient Service Requests</td>
<td>One (1) business day of receipt of a complete request</td>
</tr>
<tr>
<td>Routine Service Requests</td>
<td>Five (5) business days of receipt of a complete service request</td>
</tr>
<tr>
<td>Retrospective Service Requests</td>
<td>Fourteen (14) calendar days following receipt of a complete request.</td>
</tr>
</tbody>
</table>

**Additional Provider Access Requirements-Staffing**

ValueOptions® Florida must comply with specific ratio and geographic staffing requirements per its contract with First Coast Advantage, LLC. and the Florida Medicaid program. ValueOptions® Florida continuously evaluates the provider network to ensure all access requirements are met. These requirements are as follows:

- Facilities, service sites, and personnel sufficient to provide covered services throughout the geographic area within 30 minutes typical travel time for urban/suburban areas and 60 minutes typical travel time for rural areas for all enrolled recipients;
- At least one board certified adult psychiatrist, or one who meets all education and training criteria for board certification available within 30 minutes typical travel time for urban/suburban areas and 60 minutes typical travel time for rural areas for all enrolled recipients;
- The outpatient staff shall include at least one FTE direct service mental health provider per 1500 members that reflects the ethnic and racial composition of the community;
- At least one (1) FTE Mental Health Targeted Case Manager for twenty (20) Children/Adolescents and at least one (1) FTE Mental Health Targeted Case Manager per forty (40) adults.
- At least one (1) fully accredited psychiatric community hospital bed per 2,000 Enrollees, for both children/adolescents and adults
- The Enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter; and
• Direct service mental health treatment providers for adults and children must include providers on staff or under contract that are licensed or eligible for licensure and demonstrate two years of clinical experience in the following areas:

  • Court ordered mental health evaluations
  • Adoption/Attachment Services
  • Post-traumatic Stress Syndrome
  • Co-occurring diagnosis (mental illness/substance abuse)
  • Gender/Sexual issues
  • Geriatric/Aging Issues
  • Separation (Grief/loss)
  • Eating disorders
  • Adolescent/children’s issues
  • Sexual Physical abuse (Adult)
  • Sexual Physical Abuse (Child)
  • Domestic Violence (Child)
  • Domestic Violence (Adult)
  • Expert witness testimony
  • Bi-lingual providers

V. INITIATING CARE

It is our goal to provide access for our members to receive the most appropriate services.

ValueOptions® Florida conducts timely prior-authorization reviews in order to evaluate the member’s clinical situation and determine the medical necessity of the requested services.

Once all documentation has been received, notification of the decision will be made to the Provider within the following timeframes:

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Within forty-eight (48) to seventy-two (72) hours of receipt of completed request</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within twenty-four (24) hours of receipt of completed request</td>
</tr>
</tbody>
</table>
Non-Urgent/Routine | Within fourteen (14) days of receipt of completed request

It is the provider’s responsibility to contact ValueOptions® Florida for all services requiring authorization. ValueOptions® Florida will provide decisions within the timeframes listed in section 4.

Utilization reviewers are available by phone twenty-four (24) hours a day, seven days a week for:

- Authorization for clinical services
- Utilization review for continued stay

A determination to authorize a particular service is based on the member’s Level of Care using Florida Medicaid Level of Care Guidelines and the definition for Medical Necessity as defined by Florida Medicaid.

The following table outlines ValueOptions® Florida Medicaid authorization and concurrent review requirements:

<table>
<thead>
<tr>
<th>Service</th>
<th>Authorization Required</th>
<th>Concurrent Review Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Acute Inpatient Hospital</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Crisis Stabilization Unit (CSU)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Substance Abuse Rehab Special</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>population only –limited to pregnant members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (Facility &amp; Professional</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Clinic</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatric Electroshock Therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatric Visit/Individual Therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychological Testing*</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Targeted and Intensive Case Management</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapeutic Behavioral On-site Services (TBOS)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Individualized Treatment Plan Development</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>and Modification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation and Assessment</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical and Psychiatric Services</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Counseling/Therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Concurrent Review

Concurrent review is required for some services. Please refer to the above table in order to determine which services require review. Concurrent reviews will be conducted during the course of an enrollee’s treatment in order to determine that the treatment continues to be medically necessary as defined by Florida Medicaid and meets ValueOptions® Florida clinical criteria for the specified level of care. ValueOptions® Florida will follow the below timeframes for completion of Concurrent Review activities:

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Within forty-eight (48) to seventy-two (72) hours of receipt of completed request</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within twenty-four (24) hours of receipt of completed request</td>
</tr>
<tr>
<td>Non-Urgent/Routine</td>
<td>Within fourteen (14) days of receipt of completed request</td>
</tr>
</tbody>
</table>

If a provider determines additional services are necessary for which a pre-service review is required, the provider should contact ValueOptions® Florida at least seventy-two (72) hours prior to the end of the authorization period by phone at (855) 627-0390.

Note: ValueOptions® Florida will not retroactively authorize services requiring prior authorization. Providers have the right to submit a formal appeal for services that were not previously authorized.

Coordination of Medical Care

Network Providers are expected to identify the PCP or other primary Physical Health Provider involved in the health care of a member and coordinate the delivery of relevant care with that provider. Network Providers are required to obtain the Members written consent for release and exchange of any information pertaining to...
the Member’s treatment, however, this requirement may be waived if communication is permitted under HIPAA-permissible disclosure of PHI to a covered entity under TP&O rules or the provider may request the information from ValueOptions® Florida.

If the member refuses to issue written consent for disclosure, the Network Provider will document the refusal in the Member’s clinical record along with the reason for refusal.

All communication with the Member’s Primary Physical Health Provider should be documented in the Member’s record and indicate the date and reason for communication.

Note: ValueOptions® Florida reserves the right to monitor all network provider coordination activities through periodic on-site and off-site chart review

VI. PROVIDER APPEALS

Services are authorized based upon coverage and medical necessity criteria. These clinical criteria are developed by expert behavioral health care professionals. Criteria are revised to reflect the growing knowledge of best practice standards. Clinical criteria are applied to member’s needs and behavioral health services to determine what level and type of care should be authorized. A non-authorization or clinical denial will occur when the requested services do not meet medical necessity criteria. If you receive a clinical denial and do not agree with the decision, you have the right to appeal the decision. The “initial determination” (clinical denial) will be in writing and will include an explanation for the denial and information about the member’s and provider’s right to appeal. Clinical denials can be appealed for any level of care. Appeals can be requested at the pre-authorization stage, concurrently, or retrospectively.

It is ValueOptions® Florida intent to support consistent, timely, and accurate responsiveness to appeal requests. There are three (3) levels of appeal, which are classified as clinical and administrative. The first level of appeal is conducted by ValueOptions® Florida. If the member and/or provider are not satisfied with the response to the first level of appeal, they may file a second level of appeal with First Coast Advantage, LLC. The third and final level of appeal is conducted by the Florida Agency for Healthcare Administration (AHCA).

Clinical Appeals:
Providers and facilities have the right to initiate the appeal of any adverse medical necessity determination up to ninety (90) calendar days from receipt of notification of that determination, unless otherwise specified by regulatory requirement. Appeal requests can be made in writing, telephonically or by fax.

As part of the appeals process, a provider, or facility rendering service can submit written comments, documents, records, and other information relating to the case. ValueOptions® Florida considers all such submitted information in considering the appeal regardless of whether such information was submitted or considered in the initial consideration of the case.

Upon written request, ValueOptions® Florida will grant providers access to and copies of all documents relevant to an appeal.

Appeals considerations are conducted by health professionals (Peer Advisors) who:

1. are clinical peers;
2. hold a current active, unrestricted license to practice medicine or a health profession;
3. if medical doctors, are board-certified;
4. are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate
5. Are neither the individual who made the original non-certification, or previous appeal decision, nor the subordinate of such individual.

**Administrative Appeals:**

Participating providers and facilities have the right to initiate the appeal of any adverse administrative determination up to ninety (90) calendar days (90 calendar days for a Level II appeal) from receipt of notification of that determination, unless otherwise specified by regulatory requirement. Appeal requests can be made in writing, telephonically, or by fax.

As part of the appeals process, a provider, or facility that renders the service(s) is given the opportunity to submit written comments, documents, records, and other information relating to the case. ValueOptions® Florida considers all such submitted information in considering the appeal regardless of whether such information was submitted or considered in the initial consideration of the case.

Upon request, ValueOptions® Florida will grant providers access to and copies of
all documents relevant to an appeal.

ValueOptions® Florida standard administrative appeal system offers two levels of internal appeal, unless otherwise stipulated by contract or regulatory requirement.

Administrative Appeal reviews are conducted by the Service Center Vice President, or by staff who are designated by the Service Center Vice President for this function. Such designation may be on a case-by-case basis.

**Expedited Appeal** ValueOptions® Florida also provides an expedited process for appeals. An expedited appeal is a request to reconsider a non-authorization decision concerning admission, continued stay, or other behavioral healthcare services for a member who has received emergency services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize the life or health of the member. The member, guardian, or provider may request an expedited appeal.

An appeal is governed by specified time frames as determined by level of care and urgency of the situation. Once a decision has been made, written notification includes the rationale for the decision and subsequent appeal rights.

**Billing for Denied Care**
The member cannot, under any circumstances, be billed for denied services or for any payments resulting from the non-authorized services. Any effort to seek payment from the member is the basis for termination as a ValueOptions® Florida Provider.

**Questions regarding the appeal process should be directed to (855) 627 0390.**

**VII. PROVIDER COMPLAINTS**

ValueOptions® Florida makes every effort to provide superior service and support to all of our network providers. However, if a provider feels that their issue or concern, including issues pertaining to claims, have not been appropriately addressed and/or resolved, the provider may file a complaint. All complaints disputing policies, procedures or any aspect of the administrative functions of ValueOptions® Florida may be submitted by calling ValueOptions® Florida at (855) 627-0390, or in writing, via fax or the web. The complaint must be filed no later than forty-five (45) calendar days from the date the Provider becomes aware of the issue generating the complaint and in some cases written documentation may be
requested to complete the complaint process. Provider complaints may be filed in writing to:

ValueOptions® Florida  
Attn: Provider Relations Department  
8916 Brittany Way  
Tampa, FL 33916

ValueOptions® Florida will also ensure that the appropriate decision makers with the authority to implement corrective action are involved in the review of the Provider complaint.

At the conclusion of the review, the Provider will receive a written decision with an explanation for the decision.

VIII. PROVIDER TRAINING

ValueOptions® Florida, Inc. provides periodic training materials and sessions throughout the year through use of provider webinars, PowerPoint presentations and on-site training sessions. All new providers will receive a provider orientation providing information regarding online tools as well as a detailed overview of our provider policies and procedures. The training materials include information such as:

- Provider Handbook
- Overview of the ProviderConnect online portal
- Overview of claims filing and payment process
  - Electronic Submission Process
  - Paper Submission Process
- Review of Sample Provider Service Voucher (PSV)
- Authorization process
- Credentialing Process
- Change, add or termination of locations
- Provider direct service staff file maintenance responsibilities
- Fraud and Abuse Training
- HIPPA information
- Review of all forms
IX. NETWORK OPERATIONS

The Network Operations team is responsible for monitoring all aspects of the Provider Network. This includes, but is not limited to, Provider credentialing and recredentialing, Provider status changes and updates, geographic and specialty access, and Provider Relations activities. To contact Network Operations, please call (855) 627-0390.

Provider Network
ValueOptions® Florida offers easy access to information and services through its provider network that includes inpatient facilities, traditional providers of community mental health and targeted case management services. Network providers are located within easy access to all First Coast Advantage, LLC. Medicaid members. Staffed by mental health professionals and member service specialists, these providers serve as primary access points to care and as outreach and education centers for the Prevention, Education and Outreach programs. To obtain a list of ValueOptions® Florida providers participating in the First Coast Advantage, LLC. Network, please visit the First Coast Advantage, LLC. Network Specific link available on our website at https://www.ValueOptions.com/mc/eMember/memberLogin.do.

Credentialing/Re-credentialing

Providers are required to meet at minimum all professional standards and service descriptions outlined in the Florida Medicaid General, Community Mental Health and Targeted Case Management Handbooks. These standards are the foundation for credentialing determinations. In addition to meeting the Florida Medicaid standards, ValueOptions® Florida adheres to NCQA credentialing requirements, providers must meet the minimum requirements outlined by NCQA to qualify for participation in the ValueOptions® Florida provider networks.

To ensure all Providers are appropriately and currently credentialed, network providers must submit all updated state licensure information, accreditation(s), malpractice liability coverage, ANA authorization (for clinical nurse specialists), and DEA authorization (for M.D.s and D.O.s only). It is the responsibility of the Provider to submit current information to ValueOptions® Florida for the Provider to maintain network status. When ValueOptions® Florida receives the new information, they will update the data system and add the documentation to the
Provider file. **Failure to respond and/or submit current copies of expired items will result in termination from the network.**

Providers must notify ValueOptions® Florida within twenty-four (24) hours, of the occurrence of any of the following:

- Sentinel events regarding members
- Revocation, suspension, restriction, termination, or relinquishment of any of the licenses, authorizations, or accreditation’s whether voluntary or involuntary.
- Any legal action pending for professional negligence or alleged malpractice
- Any indictment, arrest, or conviction for felony charges or for any criminal charge
- Any lapse or material change in professional liability insurance coverage
- Revocation, suspension, restriction, termination or relinquishment of medical staff membership or clinical privileges at any healthcare facility
- Any alleged professional misconduct or ethical violations reported to state licensing boards, professional organizations or the National Practitioner Data Base.

Failure to report any of the above within the specified time frame will result in immediate suspension from the network with possible termination.

**Credentialing Audits**

Providers are subject to ValueOptions® Florida annual on-site credentialing audits. All credentialing files, or needed components, must be made available for on-site review. Providers will be notified thirty (30) days in advance to schedule an on-site credentialing audit. Providers are expected to comply with any Corrective Action Plans (CAPs) necessary to ensure compliance with Florida Medicaid standards.

**On-Site Review**

Network Operations is required to conduct on-site reviews with all non-accredited facilities, high volume individual, and group practices.

ValueOptions® Florida will conduct on-site reviews at individual and group practices, and at organizations, to assess the organization and/or provider’s office environment. Site visits may be conducted for the following reasons:

- Initial Credentialing
• Recredentialing
• When credentialed practitioner or facility requests the addition of a new practice location
• When ValueOptions® Florida receives two (2) or more member complaints within a six (6) month period related to quality issues
• Other occasions as determined by ValueOptions® Florida

For credentialing and recredentialing purposes, if a practitioner or facility is accredited by a recognized accrediting body, ValueOptions® Florida may accept the accreditation survey in lieu of performing an on-site facility review if the survey meets ValueOptions® Florida criteria. ValueOptions® Florida will accept accreditation from one of the following recognized accrediting bodies:

• National Committee For Quality Assurance (NCQA)
• Joint Commission on Accreditation of Health Organizations (JCAHO)
• The Rehabilitation Accreditation Commission (CARF)
• Council on Accreditation (COA)
• The American Osteopathic Association
• The Commission on Accreditation of Rehabilitation Facilities

**Reporting Changes**

Providers **must** notify Network Operations at least thirty (30) days prior to a change of status or address. Information can be submitted by a provider utilizing the status change form, which is available on the ValueOptions® Florida website under the network specific link for FCA, LLC., and faxing it to (813) 246-7238, or by mailing the status change form to

ValueOptions® Florida  
Attn: Provider Relations Department  
8906 Brittany Way,  
Tampa, FL 33619.

Failure to notify Provider Relations of changes may result in delay and/or denial of payment of claims payment, change in network status, or suspension or termination from the network.
Notify Provider Relations of new practice affiliations, changes in licensure, and facility or program involvement. Remember to include all important information, such as:

- Your name and name(s) of practice, facility, program
- Tax identification number and billing information
- Street address, city, state and zip
- Telephone number(s) and Fax number(s)
- Copies of new updated licenses, certifications and/or authorizations
- Copies of cover sheets for updated liability coverage

Providers should submit notification in writing, immediately of any action to suspend, revoke, or restrict an affiliated provider’s license and/or any other accreditation or certification.

**Provider Terminations**

**Voluntary:** If a Provider chooses to terminate from the network, they must provide ninety (90) days prior written notice by certified mail of intent to terminate their agreement. ValueOptions® Florida will acknowledge receipt of the request, coordinate member related services with the clinical department, and notify the Provider of the final termination, which will occur on the first (1st) day of the month following the ninety (90) day notice period.

Voluntary termination does not relieve the provider of any obligations in their contract. Providers are required to continue to provide Covered Services to Members in active treatment and ValueOptions® Florida will reimburse for Covered Services in accordance with the terms and conditions and payment rates set out in their Agreement until care can be arranged with another participating provider, for the lesser of completion of the Medicaid Member’s current course of treatment or six (6) months following expiration or termination of the Agreement.

**Involuntary:**

A provider’s participation may be terminated or suspended immediately by ValueOptions® Florida upon the occurrence of any of the following:

- Suspension or revocation, condition, expiration or other restriction of a provider’s respective license or credentials or certification
- Criminal charges related to the rendering of health care services being filed
- Termination or lapse of the insurance requirements
- A provider’s failure to remain in compliance with ValueOptions® Florida licensure and credentialing/re-credentialing standards.
- Debarment, suspension or exclusion from participation in any federal or state government sponsored health program, including without limitation Medicare or Medicaid.
- Determination of fraud
- Action or inaction that results in a threat to the health or well-being of a Member
- ValueOptions® Florida becomes aware of prior license/certification sanctions against or unsatisfactory malpractice history of a provider.

ValueOptions® Florida may suspend referrals to and/or reassign Members from a provider pending investigation of the alleged occurrences of the events listed above. ValueOptions® Florida shall notify a provider, as applicable, in writing of same.

Further, ValueOptions® Florida may terminate this Agreement immediately upon written notice to a provider in the event that there is a change in control in or any new owner or ownership is not acceptable to ValueOptions® Florida or if a provider engages in or acquiesces to any act of bankruptcy.

Recruitment and Retention of Providers

It is the policy of ValueOptions® Florida that Network Providers will be selected and retained as outlined by the State of Florida and the Agency for Health Care Administration in conjunction with all applicable state and federal laws.

As required by the State and Federal guidelines (42 CFR 438.214), ValueOptions® Florida maintains credentialing and recredentialing policies and procedures for its network. These policies document the process for credentialing and recredentialing for providers who have signed contracts or participation agreements with
ValueOptions® Florida to participate in the Florida Medicaid network. In accordance with 42 CFR 438.12;

- ValueOptions® Florida shall not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment.
- ValueOptions® Florida shall not discriminate for participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.
- When ValueOptions® Florida declines to include an individual practitioner or group of providers, in its network it gives the affected providers written notice of the reason for its decision. Nothing stated in 42 CFR 438.12 shall be construed to:
  - Require ValueOptions® Florida to contract with providers beyond the number necessary to meet the needs of its enrollees
  - Preclude ValueOptions® Florida from using different reimbursement amounts for different specialties and/or for different practitioners in the same specialty
  - Preclude ValueOptions® Florida from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

- ValueOptions® Florida shall not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. ValueOptions® Florida shall comply with additional provider selection and retention guidelines as outlined in the State Contract.

- ValueOptions® Florida network providers have a mechanism in place to notify enrollees when their direct service provider has been terminated within 15 days or prior to the next regularly scheduled appointment whichever is sooner. If an enrollee’s direct service provider has been terminated, ValueOptions® Florida network providers will ensure that a new direct service provider is assigned to the enrollee.
Provider Recruitment

ValueOptions® Florida conducts quarterly Geo Access reviews of the Provider Network to determine if additional practitioners/facilities are needed to maintain access, availability and quality standards.

When network deficiencies are detected, through Geo Access reviews or other quality data (i.e. grievances, etc.) the local Management team reviews this information.

The Management team determines if network expansion is necessary to meet all mandatory access requirements as defined by the AHCA.

Provider Retention

ValueOptions® Florida re-credentials its network every three (3) years in accordance with NCQA standards. The ValueOptions® Florida credentialing and recredentialing policies outline this process. For a copy of these policies, please contact us at (855) 627-0390.

X. MEMBERS RIGHTS AND RESPONSIBILITIES

The following section on Member Rights and Responsibilities is distributed to all Members upon enrollment in the Plan. All ValueOptions® Florida Contracted Providers are expected to provide services to our members within these Rights and Responsibilities.

MEMBER RIGHTS AND RESPONSIBILITIES

Rights

1. You have the right to be treated with respect by your counselor, doctor, and all other staff.
2. You have the right to know about and understand your illness.
3. You have the right to participate in making treatment plans with your direct service provider before treatment begins and during the course of treatment.
4. You have the right to say you do not want treatment to the extent of the law.
5. You have the right to expect that your records and conversations with your provider will be kept private (confidential).

6. You have the right to choose your own direct service provider. If you wish, ValueOptions® Florida will choose a provider for you.

7. You have the right to choose a Provider that is located closest to where you live.

8. You have the right to get mental health services without a long wait.

9. You have the right to make a first-level grievance regarding your rights or when you are not satisfied with your services. You also have the right to receive an answer about how your first-level grievance is being handled.

10. You have the right to understand how your mental health benefits work.

11. You have the right to know about mental health services administered through ValueOptions® Florida and medical services covered by First Coast Advantage, LLC.

12. You have the right to know about living wills and advance directives.

13. You have the right to request your own mental health records in accordance with applicable state laws and regulations.

14. You have the right to request an Advocate to help you understand your rights. For advocacy help, call the Florida Local Advocacy Council Hotline 1-800-342-0825.

15. You have the right to be treated with respect. A member may ask for and receive any of the rights described in this section without fear of losing services or benefits, and without fear of being treated badly or differently.

16. You have the right to make suggestions regarding ValueOptions® Florida policies on member rights and responsibilities.

17. You have the right to ask questions and receive answers to them.

18. You have the right to know about support services (including interpreters) that are available.

19. You have the right to know the rules that apply to your behavior and any consequences that may occur as a result of your behavior.

20. You have the right to be given information about other funding or resources available to you.

21. You have the right to receive treatment regardless of race, national origin, religion, physical handicap, or source of payment.

22. You have the right to receive treatment for emergency medical conditions
Responsibilities

1. You have the responsibility to treat your direct service provider with respect.
2. You have the responsibility to fully inform your direct service provider about your mental health problems and ask questions.
3. You have the responsibility to participate in the choice of treatments or medications before they are provided and during the course of treatment.
4. You have the responsibility to consider what may happen if you refuse the treatment, your direct service provider recommends.
5. You have the responsibility to help your direct service provider get your previous mental health care records or fill out new ones.
6. You have the responsibility to keep your appointments and be on time, or call your direct service provider when you are going to be late or can’t keep the appointment.
7. You have the responsibility to state your grievances, concerns, and opinions in a polite way.
8. You have the responsibility to seek mental health service from a ValueOptions® Florida service provider.
9. You have the responsibility to abide by health care and facility rules regarding your behavior and actions.
10. You have the responsibility to let your provider know if you understand your treatment plan and what is expected of you.
11. You have the responsibility to participate in your treatment plan and work with your provider to develop treatment goals that you both agree to.

XI. CORRECTIVE ACTION

ValueOptions® Florida may take certain actions should Providers fail to adequately meet any of their obligations under the terms of this contract or to comply with the requirements of this contract, ValueOptions® Florida, at its sole discretion, may undertake any or all of the following:
• Verbal communication with the Provider to discuss and gather facts regarding a concern about a policy, procedure, action, or omission with a goal of reaching a mutually agreeable resolution.

• Delivery of first notification in writing regarding a Provider policy, procedure, action or omission. This notification shall specify the specific concern and the legal, contractual or policy basis for the concern. Provider shall respond to any written notification pursuant to this section within ten (10) business days after delivery of the notification, or sooner if required by AHCA. The goal of such notification and Provider response shall be to resolve issues in a mutually agreeable manner consistent with AHCA requirements and applicable Florida statutes and administrative rules.

• Delivery of second notification in writing that specifies specific corrective action required regarding a Provider policy, procedure, action or omission, plus the legal, contractual or policy basis for the required corrective action and possible penalty.

• Provider shall affirmatively respond to the corrective action requirements within ten (10) business days after delivery of the notification or sooner if required by AHCA. Either Provider or ValueOptions® Florida may request consultation from appropriate person(s) or entities in an effort to constructively resolve the conflict. Such consultation shall be completed within ten (10) business days, unless an alternate time frame is mutually agreed. Issues involving compliance with the state contract may be referred to AHCA for interpretation. The decision of AHCA shall be binding.

• Written notification delivered by facsimile and certified mail of suspension from ValueOptions® Florida network, for an action or incident deemed to be of such serious nature that it may be cause for termination of Facility from the ValueOptions® Florida network. A copy of the correspondence will be placed in the ValueOptions® Florida file. The suspension will last for a period of fourteen (14) days during which time ValueOptions® Florida shall investigate the alleged improper action. During the suspension period, Provider will not be eligible for referrals or to begin treatment with additional Members. If it is determined that the alleged improper action has taken place, the Provider will be subject to further actions, up to and including termination from ValueOptions® Florida network.
• Notification via facsimile and certified mail of termination from ValueOptions® Florida network for an action or incident. Such termination shall be made in accordance with this Agreement. Members will be notified that Provider is no longer in the ValueOptions® Florida network and will be given assistance with referral to another Provider. For Members who are utilizing Provider at the time of termination, in Provider’s discretion, Provider shall continue to treat such Members until the course of treatment is completed or ValueOptions® Florida arranges to have another Provider render services to Members. Provider shall be compensated in accordance with this Agreement during any continuation period.

XII. CLINICAL CRITERIA

Specific information regarding ValueOptions® Florida clinical criteria is listed below for your reference. Should you have additional questions or need information on local criteria, please contact ValueOptions® Florida local service center at (855) 627-0390.

Introduction

These clinical criteria are intended for use as a guide by ValueOptions® Florida Clinical Care Management staff in determining the medical/clinical necessity and appropriate level of mental health/substance abuse (MH/SA) care for individuals receiving services through ValueOptions® Florida programs.

Clinical Philosophy

ValueOptions® Florida strives to enhance the well-being of the people we serve. We see ourselves as an integral part of the communities in which we provide service and understand that many factors impact the state of a person’s health. To best serve a given population, we seek to learn from and work with individuals in their communities in order to ensure relevant design of appropriate programs and services. As managers of the behavioral health benefits of millions of people, we are acutely aware of our responsibility to afford every opportunity for each individual to achieve optimal outcomes. We are committed to supporting individuals in becoming responsible participants in their treatment.
The clinical philosophy of ValueOptions® Florida is grounded in the provision of an understanding, compassionate environment in which the unique clinical and social needs of each individual are addressed in the context of hope and recovery. Our care management process is designed to ensure that consistent, high quality cost-effective services are provided in a culturally and linguistically competent manner. The foundation of our programs is based on:

- Clinical Excellence
- Ethical Care
- Professional Integrity
- Clinical/Technical Innovation

To further enhance our public sector clinical operations, ValueOptions® Florida, Inc. has adopted the following standards:

- Provide easy and early access to a comprehensive array of treatment and support services that includes consideration of the individual's social issues;
- Are based on the latest clinical evidence for treatment of mental illness and co-morbid disorders;
- Monitor satisfaction with the utilization management process by members, consumers, practitioners, client companies, health plans, providers and agencies;
- Work collaboratively with providers in delivering quality care;
- Address the cultural needs of the members we serve;
- Address the needs of special populations, such as children, elderly, people with serious and recurrent mental illness, child welfare, the military and their families;
- Encourage prevention, education and outreach;
- Focus on clinical and functional status and outcomes, identify problems and promote best practices to create innovation and improvement; and
- Use an accountable, data-supported continuous quality improvement (CQI) process to accomplish all of the above.

**Determining Medical Necessity**

ValueOptions® Florida clinicians must determine that proposed services are medically necessary according to the following definition.

Medically necessary services are those that are:
1. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM-IV-TR) that threatens life, causes pain or suffering, or results in illness or infirmity;
2. Expected to improve an individual’s condition or level of functioning;
3. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient’s needs;
4. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications;
5. Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available;
6. Not primarily intended for the convenience of the recipient, caretaker, or provider;
7. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency; and
8. Not a substitute for non-treatment services addressing environmental factors;

Additionally, the First Coast Advantage, LLC. state Medicaid Contract with the AHCA defines Medical Necessity as the following:

Medically Necessary – In accordance with 59G-1.010 (166) Florida Administrative Code means that:

1. The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

   a. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
   b. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the enrollee’s needs;
   c. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
   d. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
   e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee’s caretaker, or the provider.
2. “Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

**Determining the Appropriate Level of Care**

Three concepts underlie determinations of the appropriate level of care:

1. Severity of condition,
2. Intensity of service, and
3. Psychosocial, occupational, and cultural and linguistic factors.

Taken as a whole, they enable Clinical Care Managers to make determinations based on an understanding of the individual’s clinical, psychosocial, and related needs. Diagnosis alone does not determine the necessity of treatment at a given level. Individuals with the same diagnosis or one individual over time may exhibit a wide range of severity of signs and symptoms of illness or psychosocial needs. The applicability of these criteria to each individual will depend on the information obtained by the ValueOptions® Florida Care Manager from the individual, behavioral health and medical providers, family members, and other caregivers.

**Severity of Condition**

This concept addresses the question:

“What specific clinical condition exists as a result of a present DSM-IV –TR diagnosis?”

These represent the signs, symptoms, and functional impairments of such a nature and severity as to require treatment at a specified level at a given point in time. In addition, the presence of certain “high risk” clinical factors warrants consideration in evaluating an individual to determine his/her severity of condition. These factors include (but are not limited to):
Repeated attempts at self-harm, with documented suicidal intent;
Significant co-morbidities (e.g., psychiatric/medical; psychiatric/substance abuse; psychiatric/mental retardation/developmental disability; substance abuse/medical; co-morbid personality factors);
Coexisting pregnancy and substance abuse disorder;
Medication non-adherence;
Unstable Axis I or II disorder;
History of individual or family violence or assaultive behavior;
Multiple family members requiring treatment;
Decline in ability to maintain previous levels of psychosocial functioning; or
Significant impairment in one or more areas of social functioning.

Intensity of Service
This concept considers the question:

“Does the individual’s condition and situation (e.g., behavior, symptoms, psychosocial and related issues) warrant this level of care (i.e., is it medically necessary)?”

The level of care should match the individual’s condition, taking into consideration his/her developmental strengths and limitations (e.g., physical, psychological, social, cognitive/intellectual, academic) and psychosocial and related needs. Intensity of services issues are represented in Admission, Exclusion, and Continued Stay Criteria and reflect levels of service that, by virtue of their complexity and/or attendant risks, require a specified level of care for their safe, appropriate, and effective application. For example, acute mental health inpatient services may be necessary for individuals with a condition that results in the expression of suicidal/homicidal ideas, threats, plans, or attempts. It is ValueOptions® Florida’s expectation that treatment planning throughout a course of treatment is individualized, specifically states what benefits the patient can reasonably expect to receive, and discharge planning is in place from the beginning of treatment planning. While some individuals’ condition may be less serious, the presence of psychosocial, occupational, and cultural or linguistic factors (e.g., isolation, non-English speaking) may warrant a customized treatment planning (see below).

Psychosocial, Occupational, and Cultural and Linguistic Factors
These considerations represent factors that either are aggravating an individual’s clinical condition or need to be addressed in order to allow for effective treatment.
An inappropriate or more intensive level of care may be the result if the issues are not addressed. These considerations address the question:

“What specific psychosocial, occupational, and cultural or linguistic factors are present that may change the risk assessment or may present a barrier to effective treatment and should be considered when making level of care decisions?”

The following lists and discussion identify common stressors/barriers but should not be considered exhaustive.

**Psychosocial Factors**
Psychosocial factors to consider when making this determination include:

- Homelessness;
- Housing issues (e.g., risk of losing housing; inadequate housing; dissatisfaction with housing arrangements; hazardous living situation; placed at risk for abuse by current housing situation);
- Lack of effective social support (e.g., minimal social network; strained interpersonal relationships; abuse/neglect in living environment; family member/significant other with substance abuse disorder; single parent or non-parent family);
- Gender-specific issues;
- Physical disability;
- Financial difficulties;
- Lack of access to medical/dental care;
- Recent critical life event (e.g., sudden death of parent or child, divorce);
- Chronic illness;
- Isolation (e.g., rural resident, homebound);
- Lack of transportation;
- Lack of daycare;
- Active legal issues;
- Performance pressure and/or non-supportive school environment; or
- Recent release from a period of incarceration.

**Occupational Factors**
Workplace issues and/or requirements, when present, must be considered in determining the appropriate level and nature of service. When an internal or external Employee Assistance Program (EAP) exists or is involved, appropriate coordination of services with the EAP can be significant in facilitating an improved outcome. Workplace issues to consider include:
- Safety-sensitive position;
- Medical Leave of Absence (e.g., disability, workers’ compensation);
- Performance pressure/non-supportive work environment;
- Child/Elder Care issues affecting employment;
- Supervisory referral;
- EAP referral;
- Regulatory compliance issues (e.g., Dept. of Transportation); or
- Work/treatment schedule conflict.

**Cultural and Linguistic Assessment Considerations**

Unbiased knowledge of the individual’s culture and language is a prerequisite for ethical and accurate assessment. Thus, cultural and linguistic competency are an integral part of all efforts to deliver services, and are a means of ensuring access, quality, cost effectiveness, and relevant outcomes. An understanding of the relationship between culture, health beliefs, health behaviors, help seeking, recovery, illness, rehabilitation, health policy, and social policy is necessary for timely, accurate and appropriate treatment planning and interventions.

The importance of culture and language, the cultural strengths associated with people and communities, the assessment of cross-cultural relations, the cultural competence of providers, vigilance towards the dynamics inherent in cultural and linguistic differences, and the expansion of cultural and linguistic knowledge are critical.

The individual’s qualities, characteristics and choices must not be ignored in efforts to develop and implement standards and guidelines. Only consistent, quality-driven efforts toward cultural competency can lead to the establishment of best practices. A culturally and linguistically competent assessment incorporates, at all levels, the adaptation of services to meet the individual’s culturally and linguistically unique needs. As such, the individual should have the opportunity to receive an assessment and the appropriate services in his/her primary language. When the individual's culturally specific customs and communication norms guide the information sharing process, the content and accuracy of the assessment and plan are enhanced.

**Downward Substitution of Care**

Downward Substitution of Care is defined as the use of less restrictive, lower cost and medically appropriate services provided as an alternative to higher cost State Plan services.
ValueOptions® Florida use of downward substitution of care may include private practice psychologists and social workers, crisis stabilization centers and other services that ValueOptions® Florida considers more cost effective than hospital inpatient care.

**Note:** ValueOptions® Florida reserves the right to request downward substitution of care when deemed medically appropriate.

**Evaluating Necessity for Continued Care**

When evaluating the need for continued care, the Clinical Care Manager and primary behavioral health provider confirm that the treatment plan 1) remains clinically appropriate and potentially effective, and 2) reflects any psychosocial, occupational, cultural or linguistic factors that affect the level of care determination. The following factors should be considered for continuation of a treatment plan:

- Coordination with other relevant providers;
- Individual is actively participating in the plan of care and treatment to the extent possible as consistent with the individual’s condition;
- Progress in relation to specific symptoms or impairments is clearly evident and measurable, or stability at the maximum level of function has been obtained and can be sustained only by this level of care;
- Active evaluation and treatment appropriate for the condition are occurring with involvement of the individual and his/her family or other support system, with timely relief of symptoms either evident or reasonably expected;
- Treatment plan includes documented expected benefit from all relevant modalities;
- Treatment or rehabilitation goals are realistic and established within an appropriate time frame for this level of treatment;
- Psychosocial, occupational, and cultural or linguistic issues are being addressed through timely referral to and coordination with workplace, community, and psychosocial rehabilitation resources (e.g., EAP, culturally specific treatment modalities, social service agencies, peer support, recovery/self-help groups, legal aid, credit counseling, assertive community treatment, warm lines, clubhouse programs, homeless shelters);
- Discharge planning is evident; and
• All service and treatment modalities are carefully structured to achieve maximum results with the greatest efficiency in the use of resources so that the individual is treated at the least intensive level of care appropriate to the conditions and achieves the results desired (e.g., less intensive level of care, reunification of the family).

Discharge Criteria

ValueOptions® Florida expects that active discharge planning begins at the point of admission and continues throughout the treatment course. The discharge criteria reflect the circumstances under which an individual is able to transition to a less intensive level of care or can be discharged from care. In the majority of these cases, the individual’s documented treatment plan, goals and objectives will have been substantially met, and/or a safe continuing care program arranged and deployed at an alternate level of care.

It is expected that the individual is actively involved in both treatment and discharge planning. Discharge decisions and treatment alternatives are discussed with the individual throughout the course of treatment, and especially when discharge determinations are being considered. For some individuals whose condition has not stabilized but has intensified (e.g., exhibits severe behavior such as a suicide/homicide attempt), discharge will involve transition to a more intensive level of care. For children/adolescents in out-of-home placements, discharge may be prompted by reunification with parent(s), transition to an alternative living situation (e.g., foster care), or an independent living situation, or by symptoms (e.g., psychosis) that require a more highly structured setting.

In the event that benefits are exhausted, a transition plan to alternative community based resources is developed and implemented.

Clinical Criteria Development

The clinical criteria contained in this manual were developed or adopted by ValueOptions® Florida medical and clinical staff, based on information from:

• community clinicians with expertise in the diagnosis and treatment of individuals with mental illness and/or addictive disorders;
• national experts, internal experts in a particular subject area;
• standard clinical references; and
• guidelines of professional organizations.
The criteria are reviewed at least once per year and when indicated revised to reflect current best practice information from the mental health community. This process includes ValueOptions® Florida staff from the Service Centers as they interact with providers around medical necessity determinations or receive input from Clinical Advisory Committees, as new modalities or programs are identified, or based on findings published by clinical organizations or academic institutions. Proposed revisions to the clinical criteria are presented to ValueOptions® Florida’s Executive Medical Management Committee (EMMC). The EMMC meets monthly and is comprised of the Chief Medical Officers from each of the company’s operating units along with senior clinical representation from corporate departments and operating units. The Committee evaluates the proposed revision and may approve the criteria or suggest changes. Once approved, it is posted on ValueOptions® Florida’s internal website for the service centers to use for training and implementation.

ValueOptions® Florida clinical criteria address all levels of behavioral health care and are designed to facilitate continuity of care throughout the course of service delivery. To ensure that the criteria reflect the latest developments in serving individuals with psychiatric and co-morbid disorders, educational material from professional, consumer, and family member organizations such as the following are reviewed:

- American Psychiatric Association;
- American Psychological Association;
- American Academy of Psychiatrists in Alcoholism and Addictions;
- American Academy of Child and Adolescent Psychiatry;
- American Society of Addiction Medicine;
- Tricare Standards;
- Consumer and family empowerment organizations (e.g., state-based Consumer Councils; National Mental Health Consumers’ Self-Help Clearinghouse; National Alliance for the Mentally Ill; Federation of Families for Children’s Mental Health);
- International Association of Psychosocial Rehabilitation Services;
- InterQual;
- Texas Administrative Code, Subchapter HH regarding Standards for Reasonable Cost Control & Utilization Review for Chemical Dependency Treatment Centers;
- The National Institutes of Health;
- The National Institute on Alcohol Abuse and Alcoholism;
- The National Institutes of Drug Abuse;
• Department of Health and Human Services’ Center for Substance Abuse Treatment;
• Standard psychiatric texts; and
• Current publications in professional journals and books.

Account Specific Variations

The criteria outlined here reflect ValueOptions® Florida standard clinical criteria. Occasionally, clinical criteria may be modified as required by account-specific requirements. These criteria may be used as the foundation for developing criteria that are uniquely tailored to individual programs. Criteria developed for such accounts take precedence over the criteria detailed here.

Additional Clinical Criteria has been developed for special populations covered in the First Coast Advantage, LLC. contract. Please contact us at (855) 627-0390 to request copies.

The criteria sets contained in this Manual provide guidelines for the provision of clinically appropriate least restrictive and cost-effective services that promote recovery from the symptoms of mental illness and addictive disorders, and lead to recovery or stabilization at the highest level of functioning. These criteria must be applied in the context of considering other critical issues, such as an individual’s psychosocial needs, desired outcomes, and access to community resources, cultural factors, and coordination of care between behavioral health, physical health, specialty providers, and other systems of care. In addition, determinations made using these criteria must be consistent with existing ValueOptions® Florida treatment guidelines and community standards.

ValueOptions® Florida approach to clinical care management is based on the premise that individuals are more likely to access appropriate services and remain engaged in treatment when they feel that their needs are understood and met. Through application of these criteria, ValueOptions® Florida clinical staff and provider networks will be able to provide individuals with comprehensive and individualized services. These include assessment and referral to clinical practitioners and programs, coordinating a continuum of services, identifying community support resources including local support and/or self-help groups, identifying resources to meet necessities, and making available educational materials concerning mental health disorders.
ValueOptions® Florida has developed Diagnosis Based Treatment Guidelines for ADHD, Major Depression, and Schizophrenia. ValueOptions® Florida has adopted the APA’s guidelines for Bipolar Disorder and Eating Disorders. In addition, locally, ValueOptions® Florida has developed additional diagnosis based treatment guidelines in order to meet the Florida Medicaid contract requirements.

XIII. MEMBERS-ACCESSING CARE

A member can access the ValueOptions® Florida network four (4) ways:

1. A member can contact an in-network provider and request an appointment for an initial assessment to begin the treatment phase.
2. A member, family member, Provider or advocate for the member can contact ValueOptions® Florida at (855) 627-0390, 24 hours a day, 7 days a week for emergency or non-emergencies, clinical assessment, and referral to the most appropriate provider.
3. The member can be referred by their Primary Care Physician, social service caseworker, or court system through the access points described above.
4. In an emergency, the member can go to or be brought to any emergency room. A face-to-face evaluation will be performed by emergency room staff.

Referrals to Providers

Referrals to non-network Providers may be made by the ValueOptions® Florida Service Center for services that are not available within the established provider network. If authorization is not obtained prior to rendering non-emergency treatment, a denial of claims payment will result.

Outpatient Therapists: The initial authorization will define the number of sessions of psychotherapy. If the Provider believes the member needs additional treatment, he/she must submit an online authorization request through the ProviderConnectSM portal, call the ValueOptions® Florida care management staff or fax a written outpatient treatment report (OTR) prior to the expiration of the current authorization. Psychological testing requires a separate preauthorization.
Outpatient Utilization Management: The Provider is responsible for identifying any additional mental health services required by the member and conferring with the ValueOptions® Florida Service Center care management staff.

Primary Care Physician (PCP): Within the utilization management process, care must be coordinated with the member’s medical/surgical primary care physician when a possible medical disorder is identified which requires treatment or is impacting mental health treatment.

Facilities/Programs: As in outpatient care, facilities/programs receive referral authorization from the Service Center staff. In cases where the member presents at the facility/program for treatment preauthorization is still required. Utilization management representatives are available 24 hours a day, 7 days a week for case review.

Out-of-Area Care

ValueOptions® Florida is responsible for all mental health care provided to First Coast Advantage, LLC. members located in Alachua, Union, Bradford, Columbia and Marion Counties. There are no benefits available for out-of-area care except in the case of a clinical emergency, or post-stabilization services. Providers are requested to notify ValueOptions® Florida within 24 hours of determining that the member has behavioral health coverage through First Coast Advantage, LLC.

When a member has moved out-of-area, ValueOptions® Florida will make some provision for transition services for a specified length of time to facilitate the member’s process to get the address updated.

Eligibility Verification

Mental health services for Medicaid-eligible members may be covered through ValueOptions® Florida or a variety of other entities. The following information should be obtained before the first visit:

1. Confirm member’s name and Medicaid ID number

2. Call the number listed on the Member’s Plan identification card to verify eligibility.

4. For real-time verification of Florida Medicaid eligibility, we recommend verification through the use of the State of Florida’s free web site http://portal.flmmis.com/ at least once per month as eligibility is subject to change monthly.

We strongly recommend that provider verify eligibility prior to each appointment through the Florida Medicaid portal. The Florida Medicaid portal maintains the real time eligibility information.

Collection of Copayment, Co-insurance and Deductibles
Medicaid members covered through ValueOptions® Florida are not subject to co-payments or deductibles. The collection of fees directly from a Medicaid member may result in termination as a participating Provider. This includes charges for non-covered services, and missed appointments.

Members have no financial liability for:
- authorized covered services;
- authorized services not paid;
- co-payments to the provider;
- payments in excess of the contracted rate;
- missed appointments; or
- debts of the vendor or provider

The exception to this rule is the following: the member would be liable for the cost of unauthorized non-emergency contract covered mental health services, which they accessed and received from non-contract providers. There should be clear documentation that this was explained to the member and the member needs to agree in writing.

XIV. UTILIZATION MANAGEMENT

Contract Type and Review Process

Utilization review procedures vary depending on the type of contract the provider holds with ValueOptions® Florida. Additionally, utilization review is done in a
manner that supports the Medical Management Program and includes the following principles:

- Review decisions are made within URAC and CMS timeliness standards;
- Reviews are conducted using standard level of care criteria and diagnosis-based treatment guidelines;
- Reviews consider the best interests of the member; and
- Ongoing treatment reviews are conducted at a frequency dictated by the clinical issues in each case

Providers must contact ValueOptions® Florida through the online ProviderConnectSM portal, by phone or fax for review and authorization. It is the responsibility of the provider to follow ValueOptions® Florida administrative processes to obtain initial authorizations or authorization extensions in a timely manner. ValueOptions® Florida is not responsible for seeking out providers to determine if an authorization or authorization extension is needed.

ValueOptions® Florida conducts utilization review management for all levels of care as contractually required and is responsible for the following functions:

- Review treatment with Providers to verify medical necessity based on ValueOptions® Florida clinical criteria at point of access, for continuing care and discharge planning;
- Ensure that sufficient clinical information is collected and considered during the course of the evaluation;
- Ensure treatment plans are appropriate for the diagnosis and severity of symptoms;
- Ensure level of care and treatment decisions are based on medical appropriateness and necessity as described in the clinical criteria, and are designed to achieve desired member outcomes within optimal time frame;
- Ensure discharge plans are appropriate and include follow-up care plans, coordination with community resources, disposition and required referrals;
- Communicate utilization review considerations and decisions with Providers, case managers and quality improvement staff; and
• Consult with treatment team for specialized care for members with particularly difficult and complicated problems.

An authorization decision (either authorization or denial of authorization) will occur:
• At the time of initial request for care from the Provider, family member or legal guardian;
• When a treatment plan is submitted requesting further care;
• When the member or provider requests a change in level of care, or referral to another program or provider.

All utilization review decisions are based on the ValueOptions® Florida national and local clinical criteria.

All authorization decisions are made based upon the ValueOptions® Florida national and local Clinical Criteria. For specific level of care/clinical criteria.

Provider Treatment Record Reviews

ValueOptions® Florida conducts retrospective reviews of Enrollees’ records who are receiving behavioral health services to ensure services are sufficient in quantity, of acceptable quality, meet the needs of Members and meet the documentation requirements identified in the PSN Contract, the Medicaid Community Behavioral Health and Mental Health Targeted Case Management Coverage and Limitation Handbooks.

Network Provider clinical records will contain the following minimum primary components:

• Member demographics;
• Diagnosis (Axis I-V);
• Reason for admission or referral;
• Risk rating
• Mental health, chemical dependency, and/or substance abuse history;
• Medical problems (including Axis III diagnoses);
• Current medications;
• Primary Care Physician interface;
• Job, school, or community functioning;
• Psychological stressors and supports;
• Response to previous treatment;
• Treatment plan; and
• Discharge plan

For a Network Provider who plans to use Telepsychiatry and Tele-Behavioral Health Individual Therapy as a treatment modality, providers must document that the Member has freely chosen telemedicine as a treatment modality. A signed statement to this affect must be included in the record, including the time frame the acceptance is in effect. The agreement may be voided by the Member at any time. In addition, chart documentation must meet all standards outlined in Section VI, Behavioral Health Care, Item Q and Behavioral Health Clinic Records, sub-item-4. This includes:

• A brief explanation of the use of Telemedicine or Tele-behavioral health individual therapy in each progress note;
• Documentation of telemedicine equipment used for the particular covered services provided;
• The signed statement from the Member or the Member’s representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided; and
• For Telepsychiatry, the results of the assessment, findings and plan.

For Targeted Case Management, clinical records will contain the following primary components in addition to above:

• Completed Targeted Case Management Certification for either Child, Adult or Intensive;
• Assessment of the Enrollee’s needs and functioning abilities in:
  ✓ Mental Health maintenance and abstinence from substance abuse or use;
  ✓ Family support and family education;
  ✓ Educational, vocational or job training;
  ✓ Housing, food, clothing and transportation;
  ✓ Medical and dental services;
  ✓ Legal assistance;
  ✓ Development of environment supports; and
  ✓ Assistance in establishing financial resources
• Documentation supporting that the Assessment was completed within the first 30 days that the Enrollee receives MH TCM services and prior to the development of the service plan;
• Ongoing documentation that the Enrollee meets criteria for Targeted Case Management.

Additionally, ValueOptions® Florida does targeted treatment record reviews as indicated for quality purposes or as an intervention for clinical quality project interventions.

Utilization Management Guidelines

Group Therapy Services
› Although primary therapists may render group therapy, specialty therapists will provide most of this therapy with particular populations/diagnoses in groups. Contact the care management team for referral assistance in transferring an eligible member to group therapy.

Medical Care
› ValueOptions® Florida is responsible only for psychiatric authorization/management and reimbursement. Authorization for any medical care rendered in conjunction with DSM IV – ICD9 conditions must be obtained through the member’s medical plan coverage.

Inpatient Referrals to Facilities
› Therapists should always direct enrollees to an in-network facility to ensure eligibility for hospitalization benefits
› Transfer from a non-contracted facility to a facility will be required, even if it requires transfer to a different attending psychiatrist.

Emergency Treatment
› A psychiatric emergency is defined as a life-threatening situation in which the member presents a real, significant and imminent danger to self or others as demonstrated by a suicide/homicide attempt or a specific plan with means or where the member is gravely disabled due to a mental illness. A psychiatric emergency is further defined as when a person’s condition meets Baker Act (FS 394) Involuntary Evaluation Criteria.
› In all cases, make a good faith effort to contact ValueOptions® Florida at (855) 627-0390 within four (4) hours of the determination that emergency treatment is needed.
When inpatient stabilization is recommended, the attending physician will confirm emergency treatment needs within three hours and arrange admission at an facility or determine other appropriate level of care.

Post-Discharge and Post –Stabilization Coverage

- Authorization of inpatient care does not extend to outpatient care following hospitalization. Collaboration with ValueOptions® Florida care management staff, as well as therapists or programs providing aftercare, should occur before the member is released from the hospital as part of discharge planning.
- Authorization for outpatient and alternative treatment will be based on the current treatment plan and continuity-of-care concerns.
- A new authorization will be required with any change in the level of care.

XV. QUALITY MANAGEMENT

Quality Improvement Program Overview

Ongoing quality improvement is a clinical area of emphasis within ValueOptions® Florida. It is not an isolated event, but rather, it is an ongoing process that is present at all levels of the organization. Additionally, the local Quality Improvement Program involves active interface with Providers and facilities as they deliver care to plan members.

The primary objectives of the local ValueOptions® Florida Quality Improvement Program are:

- To define and implement improvements in processes that enhance clinical efficiency, provide effective utilization and focus on improved outcome management achieving the highest level of success;
- To demonstrate in its care management, specific interventions to better manage the care and promote healthier enrollee outcomes;
- To establish assessment guidelines to determine if care by Providers is rendered in a manner consistent with the highest community standards of practice.
- To maintain an integrated, system-wide reporting system to monitor and evaluate quality improvement activities at all levels and report results with recommendations in a systematic way both internally and externally, to Providers, the state of Florida and to Medicaid Enrollees;
To identify methods to meet and exceed program expectations by ensuring continuous incorporation of results into program modifications; and

To comply with all applicable Medicaid rules and regulations in the delivery of service to Enrollees.

ValueOptions® Florida has a local Senior Quality Committee that meets minimally, on a quarterly basis. The SQC is responsible for providing executive oversight and direction to the QI Program and making recommendations about TRSC’s quality improvement activities, including the annual Clinical Quality Improvement Plan and evaluation. The committee is also responsible for bringing emerging issues and opportunities under the jurisdiction of other standing committees to attention for consideration and resolution.

It is the policy of TRSC that all contractually required clinical/quality performance standards and improvement activities are monitored for compliance by a multidisciplinary team.

Contract compliance is reviewed by ValueOptions® Florida and the Quality Improvement staff using data sources that include but are not limited to:

- Clinical Review of Services and/or Service Gaps
- Medical Management Program
- Complaints, Grievances and Appeals
- Adverse/Critical Incidents
- Satisfaction Surveys
- Access and Availability Data
- Treatment Record Reviews
- Utilization Management/Administrative Data
- Readmission Data
- Performance Measures

Network Providers are expected to actively participate in the overall quality improvement process and to respond to all requests for information and quality improvement findings in a timely manner. Additionally, Problems with provider performance, interventions, and intervention results are reported to the provider, through the quality and compliance committee structure up to the Senior Quality Committee, to First Coast Advantage, LLC. and to AHCA as required.
Performance problems that are not resolved are subject to the Corrective Action Plan Policy and are monitored by the Compliance and Quality Improvement Departments and Compliance Committee.

Questions about the ValueOptions® Florida Quality Improvement activities should be directed to the Director of Quality Improvement, who can be reached at the ValueOptions® Florida local Service Center.

**Performance Measures and Functional Outcomes**

ValueOptions® Florida collects data on Enrollee Outcome Performance Measures (PMs), as defined by the Health Care Effectiveness Data and Information Set (HEIDIS), or otherwise defined by the Agency, and reports the results annually.

The QI Department develops and implements an annual QI work plan for HEDIS and other performance measures. Processes and outcomes are monitored to identify gaps in care. Gaps in care are then analyzed to determine appropriate interventions. Interventions are implemented to confirm that services are delivered effectively and documented accurately.

Results of HEDIS and other performance measures will be included in the QI program evaluation and report. The evaluation reflects barriers to care and opportunities for improvement which will be addressed in the next annual quality improvement work plan.

The FARS and CFARS were chosen for their proven inter-rater reliability and ability to assess Enrollee functioning. Various forms of the instrument are used throughout the United States that will make the sharing of best practices to achieve high functional outcomes possible. The Functional Assessment Rating Scale for adult and children is used for members upon admission to the program and every six months thereafter. Network providers will be certified in the use of the tool via online training provided by the Florida Mental Health Institute. Once certified, a Rater ID number will be generated and used on every submission as proof that a qualified individual conducted the assessment. Electronic data will be sent by the provider to the ValueOptions® Florida Service Center quarterly and data systems will be updated. All data sent in by the providers will be put into meaningful user-friendly reports and distributed to the appropriate departments and treatment teams.
FARS and CFARS electronic data submissions should be sent to TampaQi@valueoptions.com Any questions related to FARS and CFARS or the submission process may be directed to the same email address.

**Targeted Case Management**

Mental Health Targeted Case Management shall be available and offered to children/adolescents with serious emotional disturbances and adults with severe and persistent mental illness in the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook. The goal of Targeted Case Management services is to assist the enrollee in accessing needed services. Targeted Case Management services incorporate strength-based principles from the individualized service plan and clinical treatment plan.

As a network provider, it is your responsibility to ensure the intent of services as well as the qualification and certification of providers as outlined in the Health Plan Contract and the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook is met.

ValueOptions® Florida is responsible for monitoring the access and availability of Targeted Case Management services as well as the qualification and certification of providers who provide this service. This is done collaboratively through the Provider Relations and Quality Improvement Department.

Network providers are required to submit a report to the Quality Improvement Department that identifies the following:

- Name of individual certified Targeted Case Manager(s)
- The FTE of the individual Targeted Case Manager(s)
- The population that the individual(s) are serving
- The maximum number of clients on the caseload during the month
- Date of the TCM Certification
- Confirmation that the TCM Certification has been submitted to the Provider Relations Department

Targeted Case Management data submissions should be sent to TampaQi@valueoptions.com Any questions related to Targeted Case Management Services or the submission process may be directed to the same email address.
Member Satisfaction

Member satisfaction is assessed at least annually to discover areas that are working well and identifies opportunities for improvement.

When areas for potential improvement are identified from enrollee surveys or other sources (such as grievances or focused surveys), TRSC evaluates the areas identified.

Identified issues are prioritized and concerns are addressed. Interventions are implemented and the issue is reassessed to determine change and/or satisfaction.

Creating a system of care that positively impacts member clinical and functional outcomes is the goal of ValueOptions® Florida. To that end, ValueOptions® Florida employs a system that not only measures outcomes, but also puts trended member specific results back into the hands of the providers. Questions about the ValueOptions® Florida Quality Improvement activities should be directed to the Director of Quality Improvement, who can be reached at the ValueOptions® Florida local Service Center.

Critical Incident Reports

It is the policy of ValueOptions® Florida to manage care as to assure the safety of its Members through investigation and review of critical incidents. This is dependent on a fully integrated system and process of communication between VOI’s Service Center Departments and the network providers. While actions are specific to each occurrence, data is aggregated or generalized to staff training and system impact. As part of VOI’s continuous quality improvement process, activities, recommendations, problems resolution and actions taken are reviewed with staff for implementation and practice guidelines.

ValueOptions® Florida manages the tracking, review and reporting of critical incident process for its Contract. Analysis of adverse incidents is a confidential, internal risk management procedure working at the request of AHCA and for the purposes of Quality Management and related tracking.
ValueOptions® Florida reports Critical Incidents immediately and as defined in the Contract. Network Providers are required to complete information related to all critical incidents.

All critical incidents are forwarded to the Quality Improvement (QI) Department for review. QI staff review the report for required elements. When information is missing from the report, a request is sent to the provider for completion.

The QI Department, the Medical Director and Director of Clinical Operations review the critical incident and may make recommendations regarding further actions necessary, including a further investigation of the incident and follow-up actions needed. The critical incident may also be forwarded to ValueOptions® Florida Quality of Care Committee for review, investigation and to recommend follow-up action(s).

On an ongoing basis, the QI Department reviews and aggregates critical incident data to determine patterns and trends and to make recommendations for continuous quality improvement purposes.

ValueOptions® Florida Critical Incident Reports emphasize opportunities to reduce restrictive treatment interventions, injuries, or other sentinel events. Information from the review of the incident reports are used to provide:

- Modifications to therapeutic environment to promote safety and facilitate clinical services;
- Modifications to the treatment planning process to improve the outcome of care;
- Education and training for clients, staff and providers;
- Program development and planning for existing and new services;
- Service policy/procedure modification;
- Staffing needs by levels of care; and
- Prevention education and referral information.

**Treatment Record Documentation Requirements**

All network providers are required to maintain records in compliance with ValueOptions® Florida accrediting and regulatory body standards, which require that all Medical Records are maintained in a secure manner and that records will
include information about the quality, quantity, appropriateness and timeliness of services as outlined.

Treatment records are subject to audit by accrediting and regulatory bodies as part of ValueOptions® Florida accreditation process, and subject to random audits by the local Quality Management Department, First Coast Advantage, LLC. and The State Agency.

ValueOptions® Florida will enforce the maintenance of a behavioral health Medical Record for each Member. Each Member's behavioral health Medical Record will include the primary components:

- Member demographics;
- Diagnosis (Axis I-V);
- Reason for admission or referral;
- Risk rating;
- Mental health, chemical dependency and/or substance abuse history;
- Medical problems (including Axis III diagnosis);
- Current Medications prescribed;
- Primary Care Physician interface;
- General level of functioning;
- Job, school or community functioning;
- Psychological stressors and supports;
- Response to previous treatment;
- Treatment plan; and
- Discharge plan

Each Member’s behavioral health medical record will include documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of Behavioral Health Services performed.

For Providers who plan to use Telepsychiatry and Tele-Behavioral Health Individual Therapy as a treatment modality, providers must document that the Member has freely chosen telemedicine as a treatment modality. A signed statement to this affect must be included in the record, including the time frame the
acceptance is in effect. The agreement may be voided by the Member at any time. In addition, chart documentation must meet all standards outlined in Section VI, Behavioral Health Care, Item Q and Behavioral Health Clinic Records, sub-item-4. This includes:

- A brief explanation of the use of telemedicine or tele-behavioral health individual therapy in each progress note;
- Documentation of telemedicine equipment used for the particular covered services provided;
- The signed statement from the Member or the Member’s representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided; and
- For telepsychiatry, the results of the assessment, findings and plan.

For Targeted Case Management, clinical records will contain the following primary components in addition to above:

- Completed Targeted Case Management Certification for either Child, Adult or Intensive;
- Assessment of the Enrollee’s needs and functioning abilities in:
  - Mental Health maintenance and abstinence from substance abuse or use;
  - Family support and family education;
  - Educational, vocational, or job training;
  - Housing, food, clothing and transportation;
  - Medical and dental services;
  - Legal assistance;
  - Development of environment supports; and
  - Assistance in establishing financial resources

- Documentation supporting that the Assessment was completed within the first 30 days that the Enrollee receives MH TCM services and prior to the development of the service plan;

- Ongoing documentation that the Enrollee meets criteria for Targeted Case Management.
In addition to the primary components noted above, behavioral health Medical Records will be legible and maintained in detail consistent with the clinical and professional practice that facilitates effective internal and external peer review, medical audit and adequate follow-up treatment and

For each service provided, clearly identify:

- The physician or other service provider;
- Date of service;
- The units of service provided; and
- The type of service provided

ValueOptions® Florida will ensure Confidentiality of Medical Records

- ValueOptions® Florida will maintain the confidentiality of Medical Records in accordance with 42 CFR, Part 431, Sub-part F. This shall also include confidentiality of a minor’s consultation, examination, and treatment for a sexually transmissible disease in accordance with section 384.30(2), F.S.
- ValueOptions® Florida will maintain compliance with the Privacy and Security provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Except as otherwise provided by law, prior to the release of psychiatric notes to another party, specific written authorization/consent from either the Enrollee or Enrollee’s legal representative must be obtained. The written authorization/consent includes a date and signature of the Enrollee or Enrollee’s legal representative and includes documentation on the purpose of the request for release.

Complaints and Grievances

In the commitment of ValueOptions® Florida to continuous quality improvement, we encourage feedback. Members and Providers are encouraged to express their compliments, concerns, grievances to ValueOptions® Florida. Questions or concerns can be addressed either by telephone at (855) 627-0390 or in writing to:
ValueOptions® Florida
Attn: Grievance Coordinator
8906 Brittany Way
Tampa, FL 33619.

The following guidelines apply to ValueOptions® Florida complaint and grievance procedures.

- ValueOptions® Florida will manage all behavioral health complaints and grievances for Members as delegated by FCA, LLC.
- A resolution that is mutually agreeable to the provider and the member and/or family will be sought.

At no time does ValueOptions® Florida take or threaten to take any punitive action against a provider who requests an expedited resolution or supports a member’s request for an expedited resolution.

- Member benefits are continued throughout the grievance process, and at no time does ValueOptions® Florida retaliate or take any discriminatory action against an individual or provider because he/she filed a grievance.

- Grievances may be filed orally, in writing, or in person within 1(one) year of the occurrence.

- A Member may designate a representative to file grievances on his/her behalf.

- **Complaint:** Any oral or written expression of dissatisfaction by an enrollee submitted to the Health Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or Health Plan employee, failure to respect the enrollee’s rights, Health Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Health Plan’s Contract. A complaint is an informal component of the grievance system.

- All Behavioral Health Complaints from Members will be logged and tracked for timeliness
• All Member Complaints must be closed out to the Member’s satisfaction by the close of business of the second business day following receipt.

• If the complaint is not closed out in a timely manner it will be elevated to a formal grievance.

Level I Grievance: A Level 1 Grievance is any verbal or written expression of dissatisfaction with any aspect of a ValueOptions® Florida service or provider that is not immediately resolved to the enrollee’s satisfaction, about any matter other than an action. The grievant can be the enrollee, their designated representatives, or practitioners/providers with the written consent of the enrollee. When a communication is not distinguishable as an inquiry or a grievance, it is handled as a grievance. Investigation of the grievance and preparation of the letter of resolution is done by the local ValueOptions® Florida Service Center with input from the provider. All Level I Grievances will be acknowledged in writing by the local ValueOptions® Florida Service Center. The local ValueOptions® Florida Service Center and the PROVIDER will identify any significant clinical issues that require consideration and action when the initial grievance is received. Full investigation and resolution of the grievance (including any aspects of clinical care) and the written response will be completed within thirty (30) business days after the grievance was originally filed or received. Level I Grievances may be filed orally, in writing, or in person up to one year from the date of the occurrence.

If the grievance cannot be resolved within thirty (30) calendar days, an additional fourteen (14) calendar day extension can be provided if:
• requested by the enrollee
• ValueOptions® Florida justifies (upon request, to AHCA) a need for additional information and how the delay is in the interest of the enrollee.

The grievant is notified in writing before the 30th day of any requested extension. If the member does not agree to an extension, they will be offered the opportunity to have their issue addressed as a Level II Grievance. All Level II Grievances are directed to and reviewed by First Coast Advantage, LLC.

• When a grievance is received involving a member in urgent care, or when the grievant indicates that a delay in resolving the grievance might endanger the life or health of the member, investigation and resolution of the grievance will be completed as expeditiously as the member’s health condition requires or not later than seventy-two (72) hours from receipt.
All notices of determinations/resolutions include the following:

- date of filing of grievance;
- name and identifier of the grievant;
- the determination made including the date of the decision, the title(s) of the personnel and credentials of any clinical personnel who participated in each determination;
- the clinical rationale used in reaching a decision if applicable;
- the title(s) of the personnel and credentials of clinical personnel who reviewed each grievance;
- the steps taken on behalf of the member to resolve the issue;
- the name of the ValueOptions® Florida contact for any further actions or questions;
- a clear explanation of the right to a State Fair Hearing and how to file for the hearing, and;
- an explanation of any financial responsibility to the member in those rare instances where the member may bear financial responsibility for services received during the processing of the grievance if the final decision is adverse to the member.

Any grievance that contains a potential quality of care issue will be referred to the Quality of Care Committee for review and recommendations and necessary reports will be forwarded to FCA, LLC. so they can be reported to the Agency.

ValueOptions® Florida will consider issues of cultural competency when working to achieve an acceptable resolution to an enrollee grievance. This includes but is not limited to concerns related to a provider’s, or the plan’s, network capacity to provide appropriate access to care utilizing a specific language, ethnicity, or spiritual belief, as well as access to providers capable of providing services to those with physical challenges.

Members who need assistance filing grievances will receive that assistance through the use of interpreter services, specialized forms, individual coaching, or TTY services for the hearing impaired.

**Roles and Responsibilities in the ValueOptions® Florida Grievance Process**

The ValueOptions® Florida Service Center is responsible for the review and determination of all Level I the grievances related to mental and behavioral health
services provided by ValueOptions® Florida Medicaid Network Providers to Members enrolled in the First Coast Advantage, LLC.’s Provider Service Network.

**ValueOptions® Florida Grievance and Appeal Coordinator**

The ValueOptions® Florida Grievance and Appeal Coordinator is the person responsible for the ValueOptions® Florida grievance resolution system. This person is responsible for processing, monitoring and documenting grievances received regarding the local ValueOptions® Florida Service Center. The ValueOptions® Florida Grievance and Appeal Coordinator is also responsible for documenting and tracking resolution of grievances that originate at a provider location.

**Provider Grievance Coordinator:**

The Provider Grievance Coordinator is responsible for processing, monitoring, documenting, and reporting grievances involving a provider or provider location to the local ValueOptions® Florida Service Center, ensuring the necessary investigation into the grievance, and providing a resolution letter for review by the local Service Center. The Provider Grievance Coordinator is responsible for assisting the member in filling out forms and coaching the member through the resolution process.

**Fair Hearing**

A member can request a Fair Hearing at any time during the grievance process. A member may qualify for a Fair Hearing if:
1. Their request for a service has been denied, OR
2. They believe that their request was not acted upon in a timely manner.

A provider may act in the member’s behalf, with their written consent, to request the Fair Hearing.

Requests should be directed in writing to the:

**Office of Public Assistance**
**Appeals Hearings**
**1317 Winewood Boulevard, Building 5, Room 255,**
*Tallahassee, FL 32399-0700.*
Reference to the member’s right to a Fair Hearing must be included in all correspondence during the grievance process.

XVI. CONFIDENTIALITY

Distribution of clinical information to any party, except the following - a ValueOptions® Florida employee, the member’s provider, an official of Florida Medicaid, or Federal CMS, is strictly forbidden without a signed, written consent from the member. All Providers will comply with Florida confidentiality laws as contained in FS394.459 and FS490.32.

- All ValueOptions® Florida network providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- ValueOptions® Florida providers agree to safeguard the confidentiality of data and to perform certain transaction and code functions.

- ValueOptions® Florida providers must disclose certain information to each other pursuant to the terms of their provider contracts some of which may constitute Protected Health Information (“PHI”).

- ValueOptions® Florida, Inc., and its provider network intend to protect the privacy and provide for the security of PHI disclosed to the other pursuant to their provider contracts and will comply with applicable privacy and transaction and code requirements in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated thereunder by the U.S. Department of Health and Human Services (“HHS”) (collectively “HIPAA”) and other applicable federal and state laws. Certain federal or state laws may take precedence over HIPAA. ValueOptions® Florida, Inc., and its provider network agree that their contracts and the operational requirements hereunder, shall be interpreted to enable the parties to comply with either one or all of HIPAA, the Privacy Rule, HHS Transaction Standards Regulation or federal or applicable state law.

- Any Provider conducting standard electronic transactions, or on whose behalf such transactions are conducted, acknowledges that it is a Covered Entity and that it shall comply with HIPAA, the Privacy Rule, and the HHS Transaction Standards Regulation, and/or any applicable federal or state law, and any changes or amendments hereto. Providers that are Covered Entities shall also follow any
transaction and code or privacy processes or procedures as outlined by their provider contracts.

- Providers that are not Covered Entities shall comply with the coding, billing, payment, and data submission instructions contained in the Provider Handbook.

XVII. CLAIMS PAYMENT PROCEDURES

Out of Plan Emergency Services
ValueOptions® Florida assures that emergency services are available to its members who require such services. Emergency services are covered for First Coast Advantage, LLC. members through ValueOptions® Florida whether or not they are provided by network or non-network providers as long as they meet medical necessity criteria.

ValueOptions® Florida actively attempts to obtain contractual arrangements with local emergency facilities, programs, and providers; there are instances when a member will access services from non-network providers and facilities.

Limits of Liability
ValueOptions® Florida is responsible for the payment of claims from out-of-network providers related to emergency stabilization services. Facilities should make a good faith effort to notify ValueOptions® Florida as soon as possible when a First Coast Advantage, LLC. enrollee presents for emergency care related to behavioral health.

ValueOptions® Florida does not assume responsibility for non-emergency services obtained by the member from an out-of-network provider.

Reimbursement for Emergency Room services is limited to the psychiatric assessment/evaluation. Any other services, which are usually medical, need to be billed to First Coast Advantage, LLC. using the appropriate revenue and diagnosis codes.

Single Case Agreements (SCA)

ValueOptions® Florida strives to utilize only in-network providers; however, there are times when use of an out-of-network provider is unavoidable. SCA’s are used when ValueOptions® Florida negotiates a rate with Non-network provider for
specific services. Once medical necessity has been determined, ValueOptions® Florida Clinical Care Manager (CCM) coordinates the completion of the SCA with the provider/facility and ValueOptions® Florida Network Operations staff. Since the provider has agreed to the rate both verbally and in writing, there should not be any dispute about the rate.

**Note: In the event that the services are delivered and provider does not sign the paperwork, the ValueOptions® Florida standard default fee schedule will apply.**

ValueOptions® Florida will reimburse any non-participating hospital, physician, or community mental health provider for emergency services provided to its members:

- upon submission of valid, clean claims sent within three-hundred sixty five (365) days of the date of service or within the negotiated submission standard on a Single Case Agreement;
- within thirty-five (35) days of receipt of a properly submitted claim; and
- At the lessor of:
  - the rate negotiated through a Single Case Agreement;
  - the Providers billed charges
  - the usual and customary charges made to the general public by the provider; or
  - the Florida Medicaid reimbursement rate

**Helpful Tips for Getting Your Mental Health Claim Paid**

1. **Check the authorization.** Authorizations specify the number of sessions or units of care to be held within a certain time period. Make sure that the date(s) of service and sessions or units of care being billed fall within the requirements of the authorization. If further care is needed, the provider must call ValueOptions® Florida.

2. **Verify the authorized provider.** The provider named in the claim form should match the associate provider specified on the authorization.

3. **Verify eligibility.** If a member becomes ineligible for care before the number of sessions or units of care have been exhausted or the time period for the services has expired, then the authorization becomes invalid. **In order to obtain the most accurate, real-time eligibility information, providers are encouraged to verify eligibility through the Florida Medicaid online portal**
at [http://portal.flmmis.com/](http://portal.flmmis.com/). However, providers can also verify eligibility by checking a MEVS machine (i.e., Medifax), through the ValueOptions® Florida online ProviderConnect℠ portal or by calling us at (855) 627-0390.

4. **Use the correct claim form.** ValueOptions® Florida requires that providers file their claims on a CMS-1500 form. Facilities are required to use the UB-92 form.

5. **Sign the claim form.** CMS-1500 claim forms must indicate the name of the provider actually rendering the service.

**Claims Submission**

Unless otherwise identified in the provider agreement, participating providers must file or submit claims within ninety (90) calendar days from the date of service or the date of discharge for inpatient admission, or where applicable from date of determination by the primary payor. Claims after the above noted time period may be denied due to lack of timely filing. Claims must match the authorization, certification, or notification applicable to covered services for which the claim applies to avoid potential delays in processing.

Participating providers should not submit claims in their name for services that were provided by a physician’s assistant, nurse practitioner, psychological assistant, intern or another clinician.

Separate claim forms must be submitted for each member for whom the participating provider bills and it must contain all of the required data elements. Each billing line should be limited to one date of service and one procedure code.

Claims for covered services rendered to members should be submitted to ValueOptions®, a, P.O. Box 12699, Department FL – Claims, Norfolk, VA 23541-0699, or electronically through the use of on-line processes available through ProviderConnect℠ on the ‘Provider’ section of the ValueOptions® website. Participating providers are encouraged to submit claims electronically through ProviderConnect℠.

All billings by the participating provider are considered final unless a written appeal is received by ValueOptions® within the time period identified in the provider agreement, or if no time period is identified in the provider agreement within sixty (60) calendar days from the date indicated on the Provider Service
Voucher (PSV). Payment for covered services is based upon authorization, certification or notification (as applicable), and the member’s eligibility at the time of service.
Required Claim Elements
Claims for covered services rendered to members should be submitted using UB-04 or CMS-1500 forms, or their respective electronic equivalent or successor forms, with all applicable fields completed and all elements/information required by ValueOptions® Florida included.

The following is a list of CMS-1500 required claim fields:

- Insured’s ID number
- Patient’s name
- Patient’s birth date and gender
- Insured’s name
- Patient’s address, city, state, zip code and telephone number
- Patient’s relationship to the insured
- Insured’s address, city, state, zip code and telephone number
- Patient status – married / single
- Other Insured’s name, if there is other coverage
- Is the patient’s condition related to: Employment? Auto accident? Other accident?
- Other Insured’s date of birth – if there is other coverage
- Is there another health benefit plan?
- Diagnosis or nature of illness or injury - ICD-9 diagnosis code(s) - use HIPAA Compliant Codes
- Dates of service
- Place of service
- Procedures, services or supplies - use HIPAA Compliant CPT/HCPCS codes
- Procedures, services or supplies modifier
- Diagnosis pointer
- Charges
- Days or units
- Rendering Provider NPI
- Federal Tax ID number and type
- Total charge
- Signature of physician or supplier including degrees or credentials
- Name and address of facility where services were rendered
- Physician /supplier’s billing: name, address, zip code and phone number. Billing Provider's NPI
In addition, please visit www.ValueOptions.com for a complete list, instructions for completing the CMS 1500 form, and more information on proper billing procedures.

**Provider Summary Voucher (PSV)**

Provider Summary Vouchers (PSV) or Remittance Advice’s (RA) are documents that identify the amount(s) paid. *Providers/participating providers* may access PSV’s through ProviderConnect℠ or request copies of their PSV’s via facsimile through ValueOptions®’ automated PSV faxback service at (866) 409-5958. Additional information regarding access to PSV’s is available in the ‘Provider’ section on the ValueOptions® website.

**Overpayment Recovery**

*Participating providers* should routinely review claims and payments in an effort to determine if the *participating provider* has received any overpayments. ValueOptions® Florida will notify *providers* and *participating providers* of overpayments identified by ValueOptions® Florida, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to: (a) claims paid in error; (b) claims allowed/paid greater than billed; (c) inpatient claim charges equal the allowed amounts; (d) duplicate payments; (e) payments made for individuals whose benefit coverage is or was terminated; (f) payments made for services in excess of applicable benefit limitations; and (g) payments made in excess of amounts due in instances of third party liability and/or coordination of benefits.

Subject to the terms of the *provider agreement* and the applicable Florida state and/or federal laws and/or regulations, ValueOptions® Florida or its designee will pursue recovery of overpayments, according to Florida Statue 641.3155, through: (i) adjustment of the claim or claims in question creating a negative balance reflected on the Provider Summary Voucher (PSV) (claims remittance); and/or (ii) written notice of and request for repayment of the identified overpayment. Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter ValueOptions® Florida will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out and the full amount of the overpayment is recovered. ValueOptions®
Florida may use automated processes for claims adjustments in the overpayment recovery process.

In those instances in which there is an outstanding negative balance as a result of claims adjustments for overpayments for more than ninety (90) calendar days, ValueOptions® Florida reserves the right to issue a demand for re-payment. Should a provider/participating provider fail to respond and/or provide amounts demanded within the thirty (30) calendar days of the date of the demand letter, ValueOptions® Florida will pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections.

If the provider/participating provider disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the provider/participating provider may request review to ValueOptions® Florida in writing such that the written request for review is received by ValueOptions® Florida on or before the date identified in notice of overpayment recovery or request for re-payment of an overpayment. Please attach a copy of your written demand or request letter to your request for review and include the following information; provider/participating provider’s name, identification number and contact information, member name, and number, a clear identification of the disputed items to include the date of service and the reason the disputed overpayments are being contested.

Requests for Retrospective Review

Participating providers may request a retrospective review. All requests for review must be submitted in writing to the address indicated below.

ValueOptions® Florida
Attn: Grievance and Appeals Coordinator
8906 Brittany Way
Tampa, FL 33619

Please note for retrospective reviews, medical records must be received within claims timely filing limits. Timely filing limits for Network Providers (contracted) are ninety (90) days from the date of service. Timely filing limits for non-Network providers (non-contracted) are twelve (12) months from the date of service. Both the claim and the medical record must be received within these time limits.
Requests for review received beyond the above noted time period will not be reviewed and are considered ‘expired’.

**Additional Claims Payment and Management Information**

**Corrected Billings:** Claims submitted as corrected billings for the following must have clinical documentation attached supporting the correction. Providers have *thirty-five (35) days* from the date on the last PSV to re-submit corrected claims. To Expedite handling, please indicate “Corrected Billing” across the top of the claim form.

- Change of diagnosis code – why is diagnosis code being changed?
- Change of Date of Service – Why is date of service being changed?
- Change of Service Code – why is service code being changed?
- Change of place of service – why is place of service being changed?

Corrected billings received without the documentation will be returned unprocessed.

**Billing the Member**

*Providers may not bill members for covered services.*

**Authorization Letters and Provider Summary Vouchers (PSVs)**

These documents are available online or by our automated system through ProviderConnect™.

**ProviderConnect™ Portal**

Is an online service, to access ProviderConnect™ go to ValueOptions.com and choose the provider tab. All in-network providers can obtain one online registration number per provider ID number. Once you have registered you can:

- Verify member eligibility
- View authorizations
- Submit single or batch claims and view status
- Access Provider Summary Voucher (PSV)
- Submit customer service inquiries
- Submit updates to provider demographic information
- Access and print forms like electronic authorization letters

**Automated Faxback Service**
Obtain a faxed copy of your authorization letters and Provider Summary Vouchers by dialing our automated faxback service: 1-866-409-5958

XVIII. Compliance

The Compliance Department uses an Anti-Fraud Plan (Policy FCA-VOI-C601), Fraud, Waste, & Abuse Policy (Policy FCA-VOI-C600), and Corrective Action Plan Policy (Policy BH-2013-064) to guide it’s program integrity activities. Providers can access these policies off provider connect.

Program Integrity Overview

ValueOptions® Florida is responsible to First Coast Advantage, LLC. and the State of Florida for overall program integrity in the delivery of Behavioral Health services to enrollees. As it relates to services delivered by ValueOptions® Florida, the Florida program integrity activities include:

- Review of alleged illegal, unethical or unprofessional conduct
- Eligibility verification for members and Providers
- Duplicate payment prevention
- Prepayment utilization control as applied to program exclusions and limitations and detections and/or control of fraud and abuse
- Application of utilization review to detect fraud and abuse by members or Providers
- Post-payment utilization review to detect fraud and abuse by members or Providers
- Application of security measures to protect against embezzlement or other dishonest acts by employees.
- Distribution of reports on utilization or claim activity to Providers for review and action.
- Initiation of Corrective Action Plans as indicted.
- Oversight by the Program Integrity work group of the Tampa Clinical Quality Committee.

All program integrity activities will be coordinated with the ValueOptions® Florida claims payment department.
Providers are expected at all times to bill only for medically-necessary, authorized services delivered to Medicaid-eligible members. ValueOptions® Florida in conjunction with appropriate governmental agencies will actively pursue all suspected fraud and abuse.

**Reporting Fraud, Waste and Abuse**

*Providers/participating providers* should report fraud, waste and abuse, or suspicions thereof, including without limitation questionable or inappropriate billing practices (e.g., billing for services not rendered, use of diagnosis codes and/or CPT codes not evidenced in the treatment record) and/or suspicious use of or questions regarding use by a patient/member of another individual’s insurance/identification card of which the provider/participating provider is or becomes aware.

Reports and questions may be made in writing to ValueOptions® Florida at the address below or by calling the ValueOptions® Ethics Hotline at 1-888-293-3027.

**ValueOptions® Florida**

Attn: Compliance Department  
8906 Brittany Way  
Tampa, FL 33619  
tampacompliance@valueoptions.com

*Preventing Medicaid Fraud & Abuse is everyone’s responsibility.*

If you think someone is committing fraud and abuse, you can contact:

- ValueOptions® Florida Service Center 1-855-627-0390  
- ValueOptions Ethics’ Hotline 1-888-293-3027  
- ValueOptions® Florida Compliance Officer 813-246-7234  
- Florida Medicaid Fraud unit 1-866-966-7226  
- Medicaid Program Integrity Consumer Complaint Hotline 1-888-419-3456

**To file a report online go to the following website:**

XIX. CULTURAL COMPETENCY PLAN

ValueOptions® Florida is committed to achieving, in collaboration with its providers and consumers, a culturally competent system for the Medicaid Provider Sponsored Network. ValueOptions® Florida recognizes that culture influences all aspects of human behavior, in particular, its role in health maintenance behaviors and how health beliefs and practices are passed from generation to generation. Recovery, rehabilitation and reintegration are more likely to occur where systems, services, and providers have skills that are culturally competent and compatible with the backgrounds of the persons served, their families and communities.

Educational and informational materials about ValueOptions® Florida are available to enrollees and potential enrollees in English and in other languages. Translation services are also available. Other formats for written materials, such as large print, audio tape or Braille, will be available when requested through the Member Services Department.

ValueOptions® Florida will routinely collect and maintain information on each enrollee when a cultural or linguistic barrier is identified so that alternative communication methods can be made available. This information will be readily available to the Clinical Care Management staff, who will also be trained to ensure effective communication between enrollees and providers.

Training tools are available through the HHS, Office of Minority Health, including CEU credits for nurses and physicians.

For further details regarding ValueOptions® Florida Cultural Competency Plan, please contact us at (855) 627-0390.

XX. DECLARED DISASTER-CONTINUITY OF CARE

ValueOptions®, Inc. will take the following steps to ensure continuity of behavioral health care during an emergency, business disruption, impending threat or other situation. The Clinical Director (or designee) shall oversee and coordinate all actions needed to prepare for or manage continuity of care.
1. **Vulnerable enrollees**
   a. The Clinical Director will instruct all Care Managers within the Service Center to review intensive care management or other caseloads to identify any enrollees who may be particularly vulnerable during a weather-related or man-caused disaster event.

   b. Care Managers will take any clinically appropriate actions to assist vulnerable enrollees, such as contacting primary behavioral health providers to coordinate care.

2. **Inpatient Facilities**
   a. All ValueOptions® Florida contracted facilities are required to maintain plan(s) to assure the safety and care of enrollees within their facilities during disasters or emergencies.

   b. The Clinical Director (or designee) will contact all contractors providing inpatient psychiatric services within the affected area to determine:
      - The anticipated availability of inpatient services/beds;
      - The status of FCA, LLC./VO enrolled consumers residing within those facilities;
      - The Inpatient Facility’s plan for continuity of care during the anticipated event/emergency, including any need to transfer inpatient enrollees to other facilities.

   c. This communication may be via telephone, electronic communication or fax.

3. **Psychotropic Medications**
   Pharmacy benefits for ValueOptions®, Inc., enrollees are managed by the State’s Pharmacy Benefit Manager (PBM). The Medical Director (or designee) will contact the State’s PBM (or appropriate state-level representative) to:
   - Notify of the impending disaster/threat, and discuss contingency plans for continuity of care;
   - Determine the availability of PBM-contracted pharmacy dispensing locations within the service area potentially impacted during the event, and alternative pharmacy locations;
   - Determine the status of the PBM’s communications/electronic systems during the event.
   - Prepare instructions for call center staff to assist enrollees with access to psychotropic medication during the event.
4. Crisis Services
   a. Emergency Crisis Line
      The Emergency Crisis Line will remain in operation during any event. Should the local ValueOptions® Florida Service Center communications system become inoperable as the result of any event, the Emergency Crisis Line is automatically rerouted to a back-up service center with staff specifically knowledgeable of Florida resources and services.

   b. Crisis Stabilization Units
      In preparation for the event, (if known in advance) the Clinical Director (or designee) will assess the availability of Crisis Stabilization Units within the affected area, and provide instructions for call center staff so that access may be assured, including to alternative sites, if needed.

      The Crisis Stabilization Unit will ensure appropriate notification and communication with Police, Fire or other First Responders in the event of a disaster or emergency.

      For additional questions and information, please contact us at (855) 627-0390.