



College of Medicine
Department of Pediatrics
Integrated Care System (Ped-I-Care)

1701 SW 16th Avenue
Building A, Room 3111
PO Box 100296
Gainesville, FL 32608-0296
866-376-2456 (Toll Free)
352-334-1705 (Main)
352-955-6518 (Fax)

Dear Provider:

Thank you for participating as a network provider in the CMS/Ped-I-Care Provider Service Network under Medicaid Reform.

You have chosen to become a provider of this very unique network, and, as such, you have committed to the delivery of quality medical care to members of CMS/Ped-I-Care. We will work with you as a team, bringing our combined expertise to achieve the standards our community and our families expect. Together we will provide quality, coordinated care to Children with Special Health Care Needs and their siblings who are enrolled in CMS/Ped-I-Care.

This Provider Manual should answer many of your questions about CMS/Ped-I-Care and how it works. Knowing how busy you are, we have kept this manual brief, but we hope it will be helpful. If you have questions at any time or would like more detail on any of the information presented in this manual, you are always welcome to call our office at 352-334-1705 or 866-376-2456 (toll free) and ask for Provider Relations.

You are a key component in the success of this exciting new program sponsored by the University of Florida Department of Pediatrics, Children’s Medical Services, and Florida Medicaid. We look forward to working with you.

Sincerely,

Nancy M. Giunta, MHA, FACMPE
Executive Director

John Nackashi, PhD, MD
Medical Director

Mike Chen, MD
Associate Medical Director

Mark L. Hudak, MD
Associate Medical Director



Pediatric Integrated Care System

Provider Manual

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I. CONTACT INFORMATION



WHEN YOU NEED...

CONTACT...

To verify member eligibility or if you have a claims question	Use eINFOsource (INFOsource) on-line or call: Customer Service (MED3000) Phone: 800-664-0146 Fax: 866-246-2094 Hours: M-F, 8:30 AM - 5:30 PM Eastern Time
Utilization management issues: referrals, authorization of services, request for UM policies and procedures	Medical Department (MED3000) Phone: 800-492-9634 Fax: 866-256-2015 Hours: 24 hours/day – 7 days a week
To sign up for eINFOsource (previously INFOsource)	MED3000 Help Desk Phone: 866-703-1444
To access eINFOsource (previously INFOsource)	https://Pedicare.eINFOsource.Med3000.com/
To get information on the benefit package and reimbursement	http://mymedicaid-florida.com/
To submit your paper claims for CMS/Ped-I-Care services	CMS/Ped-I-Care University of Florida ICS P.O. Box 10885 Pensacola, FL 32524
To appeal claims that have been denied or underpaid	CMS/Ped-I-Care University of Florida ICS P.O. Box 10786 Pensacola, FL 32524
To arrange for or have a question about pharmacy services contact the CMS Nurse Care Coordinator for the member	Children's Medical Services Offices: Gainesville: 352-334-1400 Ocala: 352-369-2100 Daytona Beach: 386-238-4980 Jacksonville: 904-360-7070
To notify CMS/Ped-I-Care of provider/practice changes, address, telephone number, tax ID, etc., please submit in writing or call	CMS/Ped-I-Care Provider Relations Department 1701 SW 16 th Avenue, Building A Gainesville, FL 32608 Phone: 866-376-2456 (ask for Provider Relations) or local 352-334-1705 Fax: 352-955-6518
To apply for CMS provider approval	https://www.cmskidsproviders.com/eis/
To resolve contracting or procedural questions, or to request staff orientation or education	CMS/Ped-I-Care Provider Relations Department 1701 SW 16 th Avenue, Building A Gainesville, FL 32608 Phone: 866-376-2456 (ask for Provider Relations) or local 352-334-1705

Section I

Ped-I-Care Office Location

G.L. Schiebler CMS Center
1701 SW 16th Avenue, Building A
Gainesville, FL 32608
Phone: 352-334-1705
Toll Free: 866-376-2456
FAX: 352-955-6518

CMS Area Office Locations

G.L. Schiebler CMS Center
1701 SW 16th Avenue, Building B
Gainesville, FL 32608
Phone: 352-334-1400
Toll free: 1-800-523-7545
Fax: 352-334-1389

CMS – Ocala
1515 E. Silver Springs Blvd, Ste. 215
Ocala, FL 34470
Phone: 352-369-2100
Toll free: 1-888-326-7485
Fax: 352-369-2134

CMS – Daytona Beach
421 Keech Street
Daytona Beach, FL 32114
Phone: 386-238-4980
Toll free: 1-866-827-5197
Fax: 386-254-3937

CMS – Jacksonville
910 North Jefferson Street
Jacksonville, FL 32209
Phone: 904-360-7070
Toll free: 1-800-340-8354
Fax: 904-798-4569

Area 4 Medicaid Office

921 N. Davis Street, Bldg A, Suite 160
Jacksonville, FL 32209-6806
Free phone: 1-800-273-5880
Phone: 904-353-2100
Medicaid Choice Counselors:
Toll Free: 1-866-454-3959
TDD: 1-866-467-4970

II. BACKGROUND AND SERVICES

About CMS/Ped-I-Care

Ped-I-Care is a program operating under the auspices of the University of Florida, College of Medicine's Department of Pediatrics. It is constituted by and functions under a contract with the Department of Health's (DOH) Children's Medical Services (CMS) Division. CMS has designated this contracted service as a Pediatric Integrated Care System (ICS, also known as Ped-I-Care). Under Medicaid Reform CMS has partnered with Ped-I-Care to form a Provider Service Network (PSN) to provide care to children with special health care needs (up to age 21 years) and their well siblings up to the age of 21 years. It has been implemented in collaboration with the local CMS offices, which continue to provide nurse care coordination for the members and providers as well as on-going support for the pharmacy benefits program.

The program is designed to respond to the legislative intent to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program. Our goal, therefore, has been to develop a program that is sensitive and responsive to the special needs of children participating in CMS, and yet functions cost-effectively within the Medicaid funding environment. The objectives are to:

1. Develop and maintain a comprehensive provider network that offers community-based primary care and ancillary services, as well as high-quality specialty care and hospital services;
2. Develop and refine the infrastructure needed to receive, manage and account for capitated payments;
3. Deliver and coordinate quality primary and specialty care; and
4. Evaluate and continually improve the quality of service delivery, including participation in preventive care, such as Child Health Check-ups and immunizations, as well as assessment of member satisfaction.

The University of Florida Department of Pediatrics is committed to caring for children and has an established track record of collaboration with CMS in providing services to children with special health care needs. Accepting responsibility for implementing this PSN to participate in Medicaid Reform, CMS/Ped-I-Care is an important step in continuing to pursue our role as providers of health care in the environment of cost containment. We invite all our providers to work closely with us as we pursue this new and exciting opportunity to offer quality care to Florida Medicaid children.

Network Management

The Ped-I-Care office staff will assist the providers' offices with policies and procedures related to CMS/Ped-I-Care. They will respond to provider requests, questions and concerns. Examples of issues with which Ped-I-Care staff can help include:

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1. Administrative issues: Assistance with billing and claims payment, how to follow up on claim status, notification of changes in the practice;
2. Patient related issues: Primary Care Physicians (PCP) wanting to change assignment criteria or capacity;
3. Medical Management issues: Clarification on Utilization Management, e.g. benefit limits, how to get services authorized or make referrals, quality improvement procedures and reports; and
4. Requests for a Courtesy Faculty appointment in the UF Department of Pediatrics to which all members of the CMS/Ped-I-Care network are entitled.

Ped-I-Care staff also will serve as a liaison with the UF Department of Pediatrics to provide support to providers who are taking care of our children. Ped-I-Care will help providers obtain the training, consultation and other resources to help improve the management of children with special health care needs.

Ped-I-Care staff will contact the PCP's office regularly, but any provider is welcome to call us at any time at 1-866-376-2456 (toll free) or 352-334-1705.

Member Services

At enrollment into CMS/Ped-I-Care, every family will be sent a Member Handbook, Provider Directory, a letter of verification of enrollment and/or an identification card (see Section IV). If the family has not chosen or been assigned to a PCP, the ID card will not be sent until assignment is made. CMS/Ped-I-Care has a Member Services Office with a toll-free number members/families may call to ask questions, seek clarification and ask for assistance (1-866-376-2456 – ask for Member Services – or 352-334-1706). These phone lines are staffed from 8:00 A.M. until 7:00 P.M Monday through Friday. The role of Member Services is to assist members/families to obtain needed services and navigate the system with ease. Member Services will assist the provider and CMS with patient-related issues, provide information on covered and non-covered services, educate members/families on CMS/Ped-I-Care processes and policies, facilitate member access to services, update member demographic information, accept and track member complaints and grievances, and change PCP assignment at the request of members/families.

If, for any reason, a member wishes to change from the assigned PCP, services, and/or location, the member may request a re-assignment by notifying Member Services. If the request is received on or before the 15th of the month, the effective date of the change will be the first of the next month. If the request is received after the 15th of the month, the effective date will be the first of the month following the next. The member will receive a new ID card indicating the new PCP. The originally assigned PCP is expected to continue providing care until the effective date of the change, and to provide copies of all records to the new PCP.

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24-hour access for providers' questions may be obtained from 7:00 P.M. to 8:00 A.M. and on holidays and weekends through the CMS/Ped-I-Care Third Party Administrator (MED3000) at 800-492-9634.

Third Party Administrator

The University of Florida has contracted with a Third Party Administrator (TPA), MED3000, to perform several functions required to operate CMS/Ped-I-Care. MED3000 provides the Management Information System that receives and tracks membership information, adjudicates and processes claims and provides Utilization Management support through the authorization and referral processes and is responsible for concurrent review of inpatients. We are pleased that MED3000 is a member of our team.

While MED3000 adjudicates providers' claims, provider payments will be paid through Florida Medicaid.

III. PROGRAM OVERVIEW

Providing Medical Care

The goal of CMS/Ped-I-Care is to provide family-centered medical care, which includes the following elements: Whenever possible, care for all children in the family is provided by the same provider(s); the family is consulted on treatment plans; and providers work in collaboration with the CMS Nurse Care Coordinator (NCC). The NCC assists providers in maintaining family contact and compliance. They also conduct assessments of medical and psychosocial needs, and provide education and anticipatory guidance. They coordinate all services needed by the member, including those offered outside the CMS/Ped-I-Care network. Network providers should submit copies of their chart notes to the assigned NCC to facilitate care coordination.

Primary Care Physician

Every participant in CMS/Ped-I-Care has an assigned Primary Care Physician (PCP) who provides primary care and coordinates specialty care and other covered services. The PCP provides participants a medical home that ensures continuity of care and coordination of information among providers and the family. The PCP provides preventive care and anticipatory guidance according to the guidelines established by the American Academy of Pediatrics (AAP) and Florida Medicaid. PCPs provide access to phone consultation for families twenty-four (24) hours a day, 365 days a year to help families maintain the health of their children and avoid unnecessary trips to the emergency room. They track participation in preventive care and other services through documentation of care rendered and referral to specialty services. PCP specific responsibilities are outlined in the PCP provider contract.

The PCPs determine the number of CMS/Ped-I-Care participants they will accept. They also specify any other criteria for accepting patients. When initially enrolled in the CMS/Ped-I-Care network, PCPs will be asked about limits and guidelines for assignment of patients. The practice may change these guidelines at any time by contacting the CMS/Ped-I-Care Provider Relations Office: 352-334-1705 or 866-376-2456 (toll free - ask for Provider Relations).

Child Health Check-Ups (CHCUPS)

Children should receive health check-ups at:

- 2-4 days
- 2-4 weeks
- 2, 4, 6, 9, 12, 15, 18 and 24 months
- Once a year from ages 3 to 21 years

A Well Child Check-up includes:

- Hearing screening;
- Vision screening;
- Dental screening;
- Health and developmental history;
- Immunizations (when needed); and
- Treatment and/or referral as needed.

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All providers maintain complete and accurate medical records in compliance with CMS/Ped-I-Care standards and provide timely care to participants in CMS/Ped-I-Care as follows:

1. Office wait times should not be longer than forty-five (45) minutes;
2. PCPs provide well-child care within four (4) weeks of the request for service;
3. Symptomatic care is provided within one (1) week of the request and urgent care within twenty-four (24) hours;
4. Specialty evaluation and treatment for a member's condition is to be provided within thirty (30) days of the request for services by the PCP. If the PCP experiences problems getting timely care from in-network providers he/she should contact CMS/Ped-I-Care to request assistance with expediting an appointment; and
5. All providers shall offer hours of operation that are no less than the hours of operation offered to commercial HMO members or comparable to non-Reform Medicaid FFS Recipients if the Providers serves only Medicaid Recipients.

Primary Care Providers' On-Call Coverage

Primary Care Providers' coverage of services must consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of twenty four (24) hour coverage must connect the caller to someone who can render a clinical decision or reach the Provider for a clinical decision. The after hours coverage must be accessible using the medical office's daytime telephone number. The Provider or covering medical professional must return the call within thirty (30) minutes of the initial contact.

CMS/Ped-I-Care has a comprehensive network of providers; however, if a provider determines that a child needs specialty or ancillary services that are not included in the CMS/Ped-I-Care network, CMS/Ped-I-Care works with the referring provider to ensure access to needed services for members.

The CMS Nurse Care Coordinators (NCCs) assist providers in maintaining the health of children and coordinating medical care. They help to ensure that children participate in needed care and follow the provider's advice. Providers should have a system in place to follow-up on children who do not come for a scheduled visit and have not called to reschedule. The office should contact "no shows" by sending a letter or making a phone call to the family to encourage them to reschedule the visit.

If the family does not reschedule missed visits or misses two visits without calling ahead to cancel or reschedule, the office should call the NCC and ask for intervention with the family. The NCCs assist the family to participate in on-going care through identification and resolution of barriers. If the provider finds that families are not following the recommended treatment plan developed for the child, the NCC should be contacted to assist the family to engage as active participants in promoting the health of their child through good home care and following of the

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provider's recommendations. For information on how to contact the NCC assigned to your patients, see Section I of this manual.

If the provider encounters problems with patients that are not being resolved with the intervention of the NCC, the office should contact the CMS/Ped-I-Care Member Services Office, which works with the provider and the NCC to address and resolve the issue(s).

Coordinating Care

CMS/Ped-I-Care recognizes that in order to be effective in caring for children, the Primary Care Provider (PCP) needs to be involved in all services delivered to their members. The PCP should know who is providing care to the child and what recommendations have been made for additional services, including tests and procedures.

In order to support the role of the PCP in caring for the child, CMS/Ped-I-Care will require specialty services to be provided only with a referral from the PCP. Specialists who wish to refer to other specialists may do so, but must contact the PCP for the referral. The referral process required by CMS/Ped-I-Care is designed to ensure the role of the PCP in maintaining continuity of care for the member. Specialists may request authorization for needed services without going through the PCP's office; however, all specialty and ancillary providers are required to fax/mail their notes/reports to the PCP.

The NCC assists the PCP to coordinate care to the member. The NCC works closely with the member/family to ensure understanding of and compliance with needed services and recommendations for home care. In order to facilitate this role, the PCP and other providers provide copies of chart notes/reports to the NCC.

Utilization Management

All CMS/Ped-I-Care providers follow the Utilization Management guidelines specified by Florida Medicaid. Primary care services provided by the assigned PCP do not require authorization. The PCP refers to specialty services needed by the child. Some of the requested services will require authorization through MED3000.

These services can be found in the Medicaid Provider Handbooks at:

<http://portal.flmmis.com/FLPublic/Default.aspx>. Click on "Provider Support" and then "Provider Handbooks."

and the Medicaid Summary of Services Manual found at:

<http://www.fdhc.state.fl.us/Medicaid/flmedicaid.shtml>

Referrals and requests for service authorizations will be handled through MED3000 according to Medicaid guidelines. You may call 800-492-9634, fax a request to 1-866-256-2015 or go through eINFOsource on line. On May 1, 2007, MED3000 transitioned to a new on-line system called eINFOsource. If you have an INFOsource ID and password, these will be used to access the new system.

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Use of the Emergency Room/Department

Primary Care Physicians offer on-call services to members twenty-four (24) hours a day, 365 days a year, and offer expedited office services to provide assessment and management of illness. Use of the emergency department (ED) should be limited to emergencies and cases in which it is not in the best interests of the child to wait until the next office day to receive care.

It is in the best interests of the family and providers to avoid unnecessary visits to the emergency department. The UF Department of Pediatrics is available at all times to assist the PCP in triaging patients. You may call 1-800-749-7424, or in Gainesville 352-265-8000, and ask for the pediatrician on call if you need immediate consultation, or if you plan to send the child to the emergency department at Shands at UF. If making a call to ask for consultation regarding the need for urgent versus emergent care, it may be best to keep the family on the line while contacting the consulting physician.

If a child is treated in the emergency department (ED), the facility should contact the PCP to notify them of the date and reason for visit within two (2) business days. The PCP provides the ED with a referral number that should be included on the ED's claim. The PCP also provides needed follow-up. If families use the emergency department for conditions that could be managed at home or during an office visit, the PCP should contact the CMS Nurse Care Coordinator, who will contact the family to offer education and support to avoid unnecessary use of the emergency department. CMS/Ped-I-Care monitors use of emergency department services and may consult with PCPs and/or NCCs on patients who appear to make unnecessary visits.

Section III

Quality Improvement

CMS/Ped-I-Care visits each provider at least once every two years (every year for Behavioral Health) to review a sample of medical records of members. The charts are reviewed by a Quality Improvement (QI) Nurse to evaluate the measures described in this manual in Section X. The results of the site visit are summarized in a letter sent to the provider. Data related to quality measures of the program are distributed to participating providers.

Administrative Updates

Providers should notify CMS/Ped-I-Care of practice changes in writing or by phone at least thirty (30) days prior to the effective date. Changes that need to be conveyed to CMS/Ped-I-Care include:

1. Change of location, mailing address or phone number;
2. Change in tax ID number;
3. Change of practice name;
4. Practice closing;
5. Provider entering or leaving group practice;
6. Addition/deletion of hospital privileges; and
7. Addition or deletion of service sites.

IV. MEMBER ELIGIBILITY, IDENTIFICATION AND ASSIGNMENT

Member Eligibility

CMS/Ped-I-Care members are children who are enrolled in CMS because they have special health care needs and are eligible for health insurance through Florida Medicaid.

Eligibility begins at the beginning of a month and is renewed on a monthly basis. This results in a month-to-month eligibility status. Members are issued an identification (ID) card within seven to ten days of their initial enrollment in CMS/Ped-I-Care. If they have not chosen a PCP they are sent a letter verifying eligibility until they choose a PCP and receive their ID cards. (See the sample card in this section.) **Because members can drop off the program at any time after the card is issued, eligibility should always be checked before providing services, even if there is an active authorization for services on the system.** Special needs members and their siblings are eligible from birth to their twenty-first birthday.

Verification of enrollment in CMS/Ped-I-Care can be checked by using eINFOsource, the web-based database available from MED3000 that will be in operation effective May 1, 2007. Eligibility and PCP assignment will be available on-line to all providers. The initial list of eligible participants should be on-line the first week of the month. To gain access to eINFOsource, contact the MED3000 Help Desk at 866-703-1444. If you or your staff previously had access to INFOsource, the same IDs and passwords will be used to access eINFOsource.

If a patient who is no longer enrolled in CMS/Ped-I-Care presents for services, please contact the CMS nurse who is assigned to the child immediately. **Please do not refuse care before contacting the CMS Nurse.**

New Patients

CMS/Ped-I-Care respects the importance of physician-patient relationships and will make every attempt to support existing relationships. Newly enrolled members are assigned to their current primary care provider, if possible. If their provider is not in the CMS/Ped-I-Care network, and chooses not to become a participating provider (or there is no ongoing provider), the member will have to choose a new PCP.

Patients newly enrolled in CMS/Ped-I-Care appear on the enrollment information sent to PCPs at the beginning of each month. If the member is new to the practice, the office should schedule an appointment to get to know the child and request medical records from the prior PCP. The provider may contact Member Services for assistance in reaching the member and scheduling an appointment. The PCP should assess the current status of care the child has received and provide services as appropriate.

The CMS Nurse Care Coordinator (NCC) contacts the newly assigned PCP to help the PCP and office staff get to know the new member. The NCC offers information from the assessment and the care plan developed for the member. The NCC may also help to obtain the prior medical records.

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Members may request to change PCPs at any time. Transfer requests may be initiated by the member or the member's legal guardian. The member receives a new ID card indicating the new PCP. The previously assigned PCP is expected to continue providing care until the effective date of the change.

V. COVERED BENEFITS

The services provided through CMS/Ped-I-Care follow Medicaid guidelines and utilization limits. An overview of services, as well as a detailed description of each service and limit, is included in the Medicaid Handbooks. These are available through the Agency for Health Care Administration (AHCA). They can be downloaded from website: <http://portal.flmmis.com/FLPublic/Default.aspx>. Click on “Provider Support” and then “Provider Handbooks.”

Services in the CMS/Ped-I-Care benefit package include:

CMS/Ped-I-Care Covered Service Chart
Advanced Registered Nurse Practitioner Services
Ambulatory Surgical Centers
Birth Center Services
Child Health Check-Up Services
Chiropractic Services
Community Mental Health Services
County Health Department Services
Dental Services
Durable Medical Equipment and Medical Supplies
Dialysis Services
Emergency Room Services
Family Planning Services
Federally Qualified Health Center Services
Freestanding Dialysis Centers
Hearing Services
Home Health Care Services
Hospital Services – Inpatient
Hospital Services – Outpatient
Immunizations
Independent Laboratory Services
Licensed Midwife Services
Optometric Services
Physician Services
Physician Assistant Services
Podiatry Services
Portable X-ray Services
Prescribed Drugs
Prescribed Pediatric Extended Care Services (PPEC)
Primary Care Case Management Services
Rural Health Clinic Services
Targeted Case Management

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CMS/Ped-I-Care Covered Service Chart
Therapy Services: Occupational
Therapy Services: Physical
Therapy Services: Respiratory
Therapy Services: Speech
Transplant Services
Transportation Services
Vision Services

CMS/Ped-I-Care members access pharmacy services through their Medicaid benefits. Covered medications, infusion products, injectables, nutrition supplements and other prescribed drug services are to be obtained through Medicaid-participating pharmacies and durable medical equipment providers.

If specialized products, such as injectables and infusion products are not included in the Pharmacy Program, arrangements for possible payment should be made with the CMS Area Office. Only pharmaceuticals approved for use by CMS/Ped-I-Care will be covered.

Routine medications and injectables provided in a Primary Care Physician's office will be covered by CMS/Ped-I-Care and should be billed accordingly with any other services provided at the same visit.

NOTE: CMS/Ped-I-Care Medicaid members are eligible to receive vaccines through the Vaccines for Children (VFC) Program. **VFC vaccines should be used for all CMS/Ped-I-Care Medicaid Reform members. Note: VFC vaccines should not be used for CMS/Ped-I-Care Title XXI (SCHIP) program members.**

VI. UTILIZATION MANAGEMENT

CMS/Ped-I-Care has designed a utilization management program that emphasizes the important role of the Primary Care Provider (PCP) and intrudes minimally on the delivery of health care by all providers. The benefits offered by CMS/Ped-I-Care are listed in this manual (Section V) and are defined by the Florida Medicaid Program. The benefit limits are described in the Florida Medicaid Provider Handbooks available on the web at <http://portal.flmmis.com/FLPublic/Default.aspx>. Click on “Provider Support” and then “Provider Handbooks.”

Primary Care Services/Specialty Referral Process

All primary care services provided by the assigned Primary Care Provider (PCP) are to be provided at the discretion of the provider. The PCP makes referrals to **in-network** providers for specialty care.

Referral numbers are available to PCPs from MED3000 via phone, fax or eINFOsource. The referral number **must** be entered into the MED3000 system for the specialty provider to be paid. It should be given to the specialty provider accepting the member on referral, who should include the referral number on the claim form to expedite claims payment. To make a referral, use eINFOsource (formerly INFOsource), call MED3000 at 1-800-492-9634, or use the form included in this section and fax it (toll-free) to 1-866-256-2015. To arrange for access to eINFOsource call MED3000 at 1-866-703-1444.

All claims for services by specialty providers **must** have a corresponding referral number in the MED3000 electronic database that is issued by the PCP. Specialty providers who wish to refer to other specialty providers will need to involve the PCP in the referral process. The number issued to the specialist should be included on claims for any services ordered by that specialist.

Authorization Process

Requests for authorization of services should be submitted to MED3000 via eINFOsource, phone or fax using the form included in this section. The request must include relevant clinical documentation from the medical record. Faxed requests should be sent to 1-866-256-2015. If the request is urgent the provider should note the request “STAT” and call 1-800-492-9634 and ask for the Utilization Review (UR) Nurse to discuss the nature of the request. Please fax supporting documentation, signed by the requesting physician, while you are on the telephone. The more complete the request, the faster the response will be. Requests for services that lack sufficient information to make a determination will be denied if the requested information is not supplied within five (5) business days.

InterQual[®] criteria and Medicaid Coverage and Limitations Handbooks are used to evaluate requests for medical appropriateness/necessity and benefit determination. If the request meets all the criteria, it will be assigned an authorization number by MED3000.

If InterQual[®] criteria are not met or the requested service exceeds the Medicaid covered allowable, is not a covered benefit, or is a request for an out-of-network provider, the request will be forwarded to the University of Florida ICS Medical Director or Associate Director for

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review. Only the ICS Medical Director or Associate Medical Directors are able to deny a request for authorization of services.

If the child is not enrolled in CMS/Ped-I-Care, an administrative denial will be issued by MED3000. **NOTE: An active authorization listed on eINFOsource or INFOsource for a member does not guarantee that the member is still enrolled. Always check eligibility before providing services.**

Services may be authorized up to sixty (60) days in advance and the time period covered is one year (365 days) from the approximate appointment date for medical and surgical specialties, and medical supplies. Specialty providers will need to request re-authorization of services after the one year time period expires.

Authorizations for therapies (occupational, respiratory, speech and physical), home health services and durable medical equipment are valid for up to six months (180 days).

The exact time period for all authorizations is specified in eINFOsource. A seven (7) day grace period will be honored prior to and following the specified authorization time period.

If the provider has requested authorization for payment of a service that is denied, a letter will be sent to the provider, the Member and the CMS Nurse Care Coordinator, explaining the reason for the denial. The letter will be signed by the CMS/Ped-I-Care Medical Director who made the decision. **To appeal an authorization denial, please see Section VIII, Provider Appeals.**

Turnaround times for authorization of requested services are as follows:

1. Requests for authorization of non-urgent care will be approved or denied within fourteen (14) calendar days of obtaining all the necessary information. Providers will be notified of approval or denial within one (1) business day of making the decision.
2. Decisions regarding requests for authorization of urgently needed services will be made within three (3) business days or less and communicated immediately to the provider by telephone.
3. Request for authorization of services by a non-participating provider will be approved or denied within five (5) business days of obtaining all the necessary information.

Please note: Time frames begin when complete information is received by MED3000.

Services Requiring Prior Authorization

Some services require that providers obtain prior authorization (or post authorization in an emergency) before the services are performed in order to be reimbursed by Medicaid. Some services have limitations on the number of times Medicaid will reimburse for them. Exceptions to some limitations can be obtained through the prior authorization process.

The following services have specific procedure codes that require prior authorization or require prior authorization for services that exceed the service

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limitations:

- Augmentative and alternative communicative systems
- Chiropractic (over 24 visits in a year)
- Custom or motorized wheelchairs and scooters
- Dental Services (Orthodontia/Dentures)
- Durable medical equipment and medical supplies (See the Medicaid Fee Schedule for specific items requiring authorization as noted by “PA”)
- Hearing
- Private Duty Nursing
- Home Health Services
- Prescribed Pediatric Extended Care
- Inpatient Admission/Services
- Nutritional supplements
- Optometric
- Non-par, out of plan or out of state services
- Specialty Physician;
- Podiatry (over 4 visits in a year)
- Non-emergency transportation
- Vision Services (Contact Lens and Glasses)
- Therapy Services (Physical/Speech/Occupational) (Effective August 1, 2007)

Process for Requesting Authorizations

Any request for authorization of services requires a written order by the requesting physician. The physician should be available to answer questions if needed.

Authorization for services, such as DME rental, home health or therapies, will specify the units of service or time period for which authorization is given. A request for continuation of service must be submitted and/or signed by the physician before continuation of service will be pre-authorized for payment. **Authorization requests that do not have the signature of the requesting physician on the auth form or attached clinical notes will be denied.**

Information that must accompany a request for authorization is listed below. If you are requesting services that exceed the Medicaid benefit, be sure to include this as a specific component to your request. Please have this information ready if you call in the request. If you fax the request, please use the form included in this section.

1. Member name
2. Member Medicaid ID
3. Requesting provider
4. Contact person
5. PCP (if not requesting provider)

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6. Referring provider (if not requesting provider)
7. Are services result of accident (if yes, please supply type and location.)
8. Diagnosis (ICD-9 Code)
9. Clinical history/findings that justify the requested procedure
10. Attempted treatment, other consults
11. Requested care, procedure or test (CPT 4 Code or HCPCS Code)
12. Place of service (Inpatient, Outpatient, Office etc)
13. Description of service)
14. Estimated length of stay (in-patient requests)

Requests to continue service:

1. Member name
2. Member number
3. Requesting provider
4. Contact person
5. PCP (if not requesting provider)
6. Referring provider (if not requesting provider)
7. Diagnosis (ICD-9 Code)
8. Summary of treatment to date
9. Assessment of need for further treatment
10. Requested number of units of service and duration
11. Current discharge plan (inpatient services)

If the requested service is not available within the network, an authorization to use an out-of-network specialist may be requested.

Requests for Rehabilitative Services

The request for ongoing rehabilitative services (occupational, respiratory, physical and speech/language therapy) is generally made in two phases, the initial assessment and the treatment plan. A primary care or specialty physician will make the request for the initial

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assessment. If approved, the therapist will conduct the assessment and develop a proposed treatment plan. The plan must be approved by the physician, as indicated by his/her signature on the plan, but the actual request may be submitted by either the physician or the therapist. The requesting provider will be considered the physician.

Authorizations for rehabilitative services will be granted according to Medicaid Coverage and Limitations Handbook. Services may be requested up to sixty (60) days in advance and for a time period of up to 180 days. A seven (7) day grace period will be honored prior to and following the specified authorization time period.

No more than 14 units of services per therapy will be authorized per week. Up to three (3) one hour treatment visits per week will be authorized per approval from the CMS/Ped-I-Care Medical Director.

Emergency Services

When a member visits an emergency department (ED) for an outpatient visit, the ED will contact the PCP within two (2) business days. The ED should provide information to the PCP office. The PCP will schedule appropriate follow-up with the member. The PCP can obtain a referral number for Specialty Care Referrals through the use of eINFOsource (formerly INFOsource), by phoning the MED3000 Referral Department at 1-800-492-9634, or faxing the request to 1-866-256-2015.

Hospitalized Patients

Inpatient stays are monitored closely by the Inpatient Case Manager from MED3000. The Inpatient Case Manager will monitor in-patient services telephonically, with a daily call to the hospital-based Case Manager. The CMS Nurse Care Coordinators work with the hospital nurses in discharge planning. Any post-discharge services requiring authorization should be submitted to MED3000 by calling 1-800-492-9634 and asking to speak with the Inpatient Case Manager.

New Members

Patients hospitalized at the time of enrollment into CMS/Ped-I-Care, need to receive authorization for continuation of the in-patient benefits through CMS/Ped-I-Care. The Hospital or PCP should notify MED3000 at 1-800-492-9634.

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CMS / PED-I-CARE TITLE XIX REFERRAL/AUTHORIZATION REQUEST FORM

MEMBER: _____

MED3000

Member#: _____ DOB: _____

PHONE: 1-800-492-9634

PCP: _____ Requesting Provider: _____

FAX: 1-866-256-2015

Phone: _____ Phone: _____

Contact: _____ Contact: _____

Fax: _____ Fax: _____

ICD-9: _____ CPT(if applicable) _____

Check if attached: Notes Tests/studies

eINFOsource MAY BE USED

Referral to: Dr. _____ Specialty: _____

Evaluation / Consult Only treat as necessary

Referral to Podiatrist: _____ Evaluation treat as necessary (after 4visits/year)

Referral to Chiropractor: _____ Evaluation treat as necessary(after 24visits/year)

Referral to Optometrist/Optician: _____ Evaluation treat as necessary

Service / Procedure Pre-Authorization Requested

NOTES REQUIRED FOR MEDICAL REVIEW

Inpatient admission/Service: (including planned surgery or procedure)

Facility: _____ Date of Adm: _____

Non-par, out of plan or out of area Hospital Services: _____

Facility: _____ Date of Svc: _____

DME/Medical Supplies: _____

Provider: _____

Custom/Motorized Wheelchairs/Scooters: _____

Provider: _____

Nutritional Supplements: Type: _____

Home Health Services: #Visits _____

Private Duty Nursing: # of Hours _____

Start Date _____ Stop Date _____

Provider: _____

Prescribed Pediatric Extended Care: Facility: _____

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Augmentative/Alternative Communicative systems: _____

Provider: _____

Hearing Services: _____ Evaluation Hearing Aids

Dental Services: _____ Evaluation Orthodontia Eval./Treat as necessary

Dentures

Vision Services: _____ Contact Lens (Aphakia) Glasses 2 pair/year

PT / OT / Speech / Respiratory therapy: #Visits: _____ # Units _____

Facility: _____

Authorization #: _____ Units: _____ Date Range: _____

VII. BILLING AND CLAIMS PAYMENT

CMS/Ped-I-Care claims are processed by the Third Party Administrator, MED3000 and passed on to Florida Medicaid/EDS for payment. Services are paid for at the prevailing Medicaid rate and will follow Medicaid guidelines for service limits. Payments are made according to the Utilization Management policies described in the Medicaid Handbooks **and shall be made in accordance with applicable state and regulatory guidelines.**

CMS/Ped-I-Care only processes claims for services provided to children who are enrolled in CMS/Ped-I-Care during the month in which the service is provided. **If a child loses eligibility for CMS/Ped-I-Care, the provider should contact the CMS Office for consultation on payment options.**

Physician extenders (ARNPs and Physician Assistants) may bill “incident to” an enrolled provider in accordance with Medicaid guidelines. The physician must be on-site during the visit/service provided and must sign the chart. ARNPs also may bill in their own names, although the supervising physician must be on site in order for the child to be seen. They must be currently licensed, operating within the scope of their profession and in accordance with the protocols established by the provider under whose authority they practice. ARNPs will be paid at 80% of the physician’s reimbursement rate.

In order to be paid, a claim must meet the following criteria:

1. Member must have been enrolled in the month service was delivered
2. Service is a covered and authorized benefit
3. Provider must be enrolled in the CMS/Ped-I-Care network (unless out-of-network services are authorized)
4. Uses HIPAA and Florida law compliant format for claims submission [CMS 1500 (08-05), UB-04]
5. Claim must be complete and accurate (See Note below regarding NPI numbers)
6. Claims for specialty services and procedures need to include the referral/authorization number
7. Procedure must be consistent with the diagnosis code listed on the claim
8. Claims must be submitted **within 365 days** of the date of service

Send paper claims to:

University of Florida CMS/Ped-I-Care
P.O. Box 10885
Pensacola, FL 32524

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Electronic claims are the preferred method of claims submission. This can be arranged directly with MED3000 by completing the set-up sheet included in this section and faxing it as requested or by calling the MED3000 Help Desk at 1-866-703-1444.

CMS/Ped-I-Care providers must accept the payment made through the ICS by Florida Medicaid as payment in full and may not request payment from CMS/Ped-I-Care members or family members. If your claim cannot be paid as submitted, Florida Medicaid will give the reason on the Explanation of Benefits (EOB) that will accompany every payment to your office. Claim payment will be made in accordance with state and regulatory guidelines.

If you have questions about the payment or the EOB, please contact MED3000 Customer Service at 1-800-664-0146. They will respond to your questions or concerns. If, after talking with them you wish to appeal a claim, you should follow the procedures described in this manual (see Section VIII).

MED3000 offers eINFOsource (which replaced INFOsource on May 1, 2007), a web-based application that will allow providers to check on the status of claims, to verify eligibility and to obtain referral numbers and authorization and referral information. This will provide accurate and timely information, while decreasing time spent on the phone.

For more information or to establish a login for your office, please contact the MED3000 Help Desk at 1-866-703-1444.

NOTE: As of May 23, 2008 claims were required to be filed using your National Provider Identifier (NPI) number(s). This number must be registered with Florida Medicaid. As of May 23, 2008 your Florida Medicaid “legacy” provider numbers were no longer accepted on claims and claims were denied if they were filed with this number.

PLEASE REMEMBER THAT CLAIMS FOR APPROVED AND AUTHORIZED SERVICES WILL BE PAID ONLY IF THE MEMBER IS ENROLLED IN CMS/PED-I-CARE DURING THE MONTH OF SERVICE. ELIGIBILITY CAN CHANGE AND MUST BE VERIFIED EACH MONTH and/or PRIOR TO RENDERING SERVICES.

Please note that CMS/Ped-I-Care has implemented a Compliance Plan and will be auditing claims for potential fraud and abuse under the terms of our contract with DOH/AHCA. Please see Section XVII for more information on our Compliance Plan.

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Clearly The Best.

5020 Commerce Park Circle
Pensacola, FL 32505

Dear Provider:

MED3000 is providing claims services in conjunction with the University of Florida Integrated Care System. Electronic Claim Submission can provide for more timely and accurate payment of your claims. We encourage providers to take advantage of this opportunity. If you are interested in learning more about this process, please take a moment to complete the Setup Worksheet and fax it to us.

Please fax the form to 1-866-595-5511. Once we have your information we will be in touch with your office. We are looking forward to the opportunity to work with you and your office staff.

Sincerely,

A handwritten signature in cursive script that reads "Dee Bryant". The signature is written in black ink on a light-colored background.

Dee Bryant\Senior Director
MED3000 Managed Care Operations

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MED3000, Southeast Region
Fax to: 1-866-595-5511

ELECTRONIC CLAIMS TRANSMISSION
SETUP WORKSHEET

DATE _____

PRACTICE NAME _____

PRACTICE ADDRESS _____

PHONE NUMBER () _____ FAX NUMBER () _____

CONTACT PERSON _____

EMAIL ADDRESS _____@_____

PRACTICE MANAGEMENT VENDOR _____
(Who you purchased your software from)

ADDITIONAL COMMENTS _____

PHYSICIAN INFORMATION

PROVIDER NAME	MED3000 PROVIDER ID	UPIN NUMBER

BELOW INFORMATION TO BE ASSIGNED BY MED3000

LOGON INFORMATION

DATA FILE INFORMATION

USER NAME _____ DATA FILE NAME _____

PASSWORD _____ TESTED _____

APPROVED _____

SETUP COMMENTS _____

Section VIII

VIII. PROVIDER APPEALS/GRIEVANCES

Claims Payment/Denial Appeals

The response to all claims submitted from providers will be documented on the Explanation of Benefits (EOB) sent to the billing provider by Florida Medicaid. Each claim submitted is noted as paid or will include an explanation of the reason for non-payment. If the provider thinks there has been an error in the denial or has any questions about the interpretation of, or disagreement with the adjudication, he/she should contact MED3000 Customer Service at 1-800-664-0146. MED3000 staff will attempt to clarify or resolve any issues with the claims payment process.

First Level Appeal

If not satisfied with this initial response, the provider may submit a formal appeal. This must be done in writing within sixty (60) calendar days from the date of the EOB using the form included in this section of the manual (p.35).

The appeal request must consist of:

1. The completed appeal form
2. Documentation supporting the request
3. Copy of the original claim

The appeal should be mailed to:

University of Florida ICS
Claims Appeals
PO Box 10786
Pensacola, FL 32524

The appeal will be reviewed and researched by MED3000 staff and forwarded to the Manager of Claims Services for final determination. If payment is denied by MED3000, the provider will receive a written response within forty-five (45) days of MED3000's receipt of the appeal.

Second Level Appeal

If the first level appeal is denied, the provider may file a second level appeal that will be submitted in writing to MED3000 using a copy of the original appeal form (with "Second Level Appeal" box checked) or a second completed form with "Second Level Appeal" noted. Additional supportive documentation should be attached to the appeal form.

The second level appeal must be submitted within fifteen (15) days of the receipt of the denial of the first appeal. The second level appeal shall be mailed to MED3000 at the above Claims Appeals address. MED3000 staff will forward the appeal to the CMS/Ped-I-Care Executive Director (or designee).

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The second level appeal will be reviewed within fifteen (15) business days by a committee consisting of the CMS/Ped-I-Care Executive Director, Claims Manager, the Network Manager and the ICS Medical Director. If the claim is denied, the provider will be mailed a denial letter within five (5) business days of the decision.

Third Level Appeal

If the provider is not satisfied with the response to the second level appeal, he/she may file a request for a meeting, during which the case for the appeal will be presented to the committee that made the second level appeal decision, along with the Vice Chairman of Managed Care for the Department of Pediatrics (or his designee), representation from the Health Center Risk Management Office and representation from the Fiscal Division of the local area CMS Office. The request must be submitted within fifteen (15) business days of the denial of the second level appeal. The committee will convene within thirty (30) calendar days of the request and the provider will be informed of the committee's decision within fifteen (15) business days of the meeting.

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**University of Florida Integrated Care System (CMS/Ped-I-Care)
Title XIX Claims Payment Appeal Form**

This form has been developed to assist you in notifying the Claims Department of appeal issues.

Appeals need to be received within 60 days of notification of a denial or payment issue (i.e. within 60 days of the EOB date).

Provider of Service (Physician or Facility) Medicaid Number

Address (Number, City, State, Zip)

Telephone Fax

Contact Person Date

Claim Summary Information

Member Name Member ID

Claim Number from EOB Date of Service

Type of Appeal (Check all that apply): First Level Appeal Second Level Appeal Third Level Appeal
 Payment Issue Timely Filing Authorization Issue

Requested Documentation Attached Other _____

Please provide detailed explanation for appeal. Be sure to include all supporting documentation; i.e. copy of denial from EOB, copy of original claim, copy of electronic submission confirmation form for timely filing, pertinent clinical notes, etc. Attach additional sheets in necessary.

Mail completed form and documentation to:

**CMS/Ped-I-Care Claim Appeals
University of Florida ICS
P. O. Box 10786
Pensacola, FL 32524-0786**

Section VIII

Utilization Management (Authorization) Appeals

Nationally recognized criteria for medical necessity (InterQual) and the Medicaid Coverage and Limitations Handbooks are used to evaluate requests for medical appropriateness/necessity and benefits. If the request meets all the criteria, it will be assigned an authorization number by MED3000.

If InterQual criteria are not met or the requested service exceeds the Medicaid covered allowable, is not a covered benefit, or is a request for an out-of-network provider/service, the request will be forwarded to the University of Florida ICS Medical Director for review. Only the ICS Medical Director or Associate Medical Director are able to deny a request for authorization of services.

If the request for authorization for services is denied, a phone call will be made to the provider within one (1) business day of the decision, followed up by a letter to the provider, the member and the CMS Nurse Care Coordinator, explaining the reason for the denial. The letter will be signed by the CMS/Ped-I-Care Medical Director who made the decision.

First Level Appeal

The provider or the member's parent/guardian (but not both) may submit a written appeal of this decision. An appeal must be submitted in writing within thirty (30) days of notification of the denial, or within three (3) business days to be considered for an expedited appeal. The appeal must be filed using the form that is contained in this section (p. 38) or may be requested from CMS/Ped-I-Care by calling 1-866-376-2456 or 352-334-1705 (ask for the Authorization Appeals Coordinator). It should be mailed to CMS/Ped-I-Care Authorization Appeals Coordinator, 1701 SW 16th Avenue, Building A, Gainesville, FL 32608, or faxed to 352-955-6518. The appeal will be reviewed by a CMS/Ped-I-Care Medical Director who was not involved in the initial decision. The provider will be notified within thirty (30) calendar days if the appeal is denied.

Second Level Appeal

Providers will be given the opportunity for a second level appeal, in which they will be able to present their request to a committee that includes experts in the relevant area. They must request this appeal in writing within thirty (30) calendar days of denial of the first appeal. The committee will notify the provider within thirty (30) calendar days of its decision.

Expedited Utilization Management Appeals

Expedited appeals must be requested within three (3) business days from the denial and meet the following criteria:

CMS/Ped-I-Care must have made a determination that coverage will not be provided for health care services because such services do not meet CMS/Ped-I-Care's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and,

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The member's life or health, or the member's ability to regain optimum function, would be seriously jeopardized or would subject the member to severe pain that cannot adequately be managed without the care or treatment that is the subject of the request, by waiting for CMS/Ped-I-Care to review its denial through the standard appeals process time frames; and,

1. The provider refuses to provide the service(s) until coverage or payment is guaranteed by CMS/Ped-I-Care or the member; and,
2. The CMS/Ped-I-Care Medical Director confirms the request meets the criteria for expedited review.

The following time frames apply to expedited appeals:

1. The initial appeal must be filed within three (3) business days
2. The provider will be notified by telephone within three (3) business days of the response to the appeal and followed up with a written response
3. A second level expedited appeal must be filed within three (3) business days from the first level denial
4. A meeting or a conference call will be scheduled within ten (10) business days to address the next level of appeal
5. The provider will be notified by telephone within three (3) business days of the decision on the second level appeal.
6. All of these time frames may be lengthened if both parties agree. If the patient's condition mandates a more rapid response to the appeal request than these guidelines allow, CMS/Ped-I-Care will do everything possible to expedite and hasten the process.

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Pediatric Integrated Care System



Authorization Denial Appeal Form

Please complete this form and mail it to: CMS/Ped-I-Care, Attn: Authorization Appeals Coordinator, 1701 SW 16th Avenue, Building A, Gainesville, FL 32608. Or, you may fax it (352) 955-6518. If you have trouble completing this form, you may call CMS/Ped-I-Care for assistance at (352) 334-1705 or Toll Free (866) 376-2456.

Name of member: _____

Member ID number: _____ DOB: _____

Name of person submitting the appeal: _____

Mailing address: _____

Phone number(s): _____ Fax number: _____

Relation to member*: _____

* If provider, appeal must be submitted by physician who ordered the service

Provider name and name of practice: _____

Address of practice: _____

Phone number(s): _____ Fax number: _____

Type of service denied: _____

Additional clinical information provided with appeal? Yes ___ No ___

Please explain why service(s) should be approved: _____

(For Office Use)

Date appeal received: _____ Medical Director: _____

Date returned from Medical Director: _____ Date submitted to MED3000: _____

Date decision notification sent to member & provider: _____

Results: Denial Upheld ___ Authorization Approved ___

Section VIII

Provider Complaints/Grievances

Providers may file a complaint to dispute CMS/Ped-I-Care's policies, procedures or any aspect of CMS/Ped-I-Care's administrative functions. To file a complaint, providers may call 1-866-2456 or 352-334-1705 and ask for a Provider Relations representative. Complaints should be filed within 45 days of the incident responsible for initiating the complaint. Provider Relations will review the complaint, bringing in any other necessary parties to collect all pertinent facts, and respond to the complainant in five business days or less.

A grievance may be filed on any serious issue or when the usual protocols have been exhausted and the provider is still dissatisfied. To file a grievance, call the CMS/Ped-I-Care Office and ask for the Grievance Coordinator. The Grievance Coordinator will send the appropriate form to the provider on which to document the reason(s) for the grievance. A copy of this form is included in this section (p. 41). If the provider would prefer to file the grievance verbally, the Grievance Coordinator will note the specifics of the grievance. A provider may file a complaint or grievance on behalf of a member.

The ICS Medical Director will convene the Provider Grievance Committee within fifteen (15) business days of receiving the written grievance. The Committee will consist of the ICS Medical Director, ICS Executive Director, Network/Provider Relations Manager, a representative from the Risk Management Office, and other specialists/resources appropriate to the situation. The provider may participate in the Grievance Committee meeting. A final decision will be made by the Provider Grievance Committee and communicated by mail to the complainant within ten (10) business days following the meeting.

The letter of disposition will include notification that the complainant has the option of appealing to the Statewide Children's Medical Services Grievance Panel. The letter will contain information on how to pursue this option.

Other Issues and Concerns

Concerns about CMS/Ped-I-Care members may be directed to the member's CMS Nurse Care Coordinator (NCC) or to the CMS/Ped-I-Care Member Services Office (1-866-376-2456 or 352-334-1705). Other issues and concerns should be directed to CMS/Ped-I-Care staff at 352-334-1705 or 1-866-376-2456. This process will be informal and handled verbally, unless otherwise requested by the provider.

Providers may call CMS/Ped-I-Care and ask for Network Management or Provider Relations staff or express their concerns when Network Management staff make their regular contact with providers.

The Network Manager and Member Services Manager will maintain a log of issues of concern to providers and will report them to the CMS/Ped-I-Care Executive Director and to the Quality and Utilization Management Committee (QUMC) at the quarterly meeting. These will be reviewed and any trends noted for possible improvements in the system or services rendered by CMS/Ped-I-Care or its subcontracted TPA, MED3000.

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If providers wish to submit comments or concerns in writing, they may be sent to the Network/Provider Relations Manager:

Network/Provider Relations Manager - CMS/Ped-I-Care
1701 SW 16th Avenue, Building A
Gainesville, FL 32608

If the provider would like a complete description of the provider complaint/grievance system, a request may be sent to the address above or the provider can call Provider Relations at 352-334-1705 or 1-866-376-2456.

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UNIVERSITY OF FLORIDA



PEDIATRIC INTEGRATED CARE SYSTEM PROVIDER GRIEVANCE FORM

Please completely fill out this form and mail it to the following address:

Ped-I-Care, ICS
Attn: Grievance Coordinator
1701 SW 16th Ave., Bldg. A, Rm. 2165
Gainesville, FL 32608

Phone: 352-334-1705
Toll free: 866-376-2456
Fax: 352-955-6518

Date of Grievance: ___/___/___ (please enter today's date)

Name: _____ (please include M.D., D.O., etc.)

Facility Name: _____
(please include D/B/A name)

Address: _____

Phone #: _____ Backline #: _____ Fax #: _____

County: _____

Type of Grievance: [] Claims Issue [] Member Assignments [] Other _____

Please explain the reason you are filing this grievance (Please submit any documentation related to this grievance, if any): _____

Please provide contact information for any person(s) who have additional information regarding this grievance, if any:

Please tell us what you would like to have happen as result of this grievance procedure:

IX. MEMBER RIGHTS, RESPONSIBILITIES AND COMPLAINTS

Member Rights

Each member/family has a right to:

1. Be treated with respect, courtesy, and with recognition of their dignity
2. Protection of their privacy
3. A prompt, courteous and responsible response to their questions and requests
4. Information about diagnosis, treatment options, and prognosis
5. Have the medical record and all other information kept confidential, unless permission to release such information has been given by the member or their caretaker, or the release is required by law
6. Participate in decisions regarding health care provided to themselves/their child
7. Receive information about CMS/Ped-I-Care and its services and policies
8. Express complaints or grievances regarding the program or care provided

Member Responsibilities

Members and/or family members are responsible for:

1. Giving health care providers accurate and complete information regarding their child's health
2. Reporting unexpected changes in their child's health to the health care provider
3. Accessing specialty and ancillary services only when referred by the PCP and using only in-network providers, unless prior authorization is given
4. Keeping appointments and being on time, or calling providers to reschedule
5. Carrying their CMS/Ped-I-Care identification card at all times to present to each health care provider before receiving services
6. Calling CMS/Ped-I-Care Member Services Office if the family has a change in address or telephone number
7. Following the plan of treatment outlined by the provider or, if not possible, to request a new plan of treatment
8. Notifying the PCP within one (1) business day if they use the emergency room for services

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Member Complaint and Grievance Procedures

Participants enrolled in CMS/Ped-I-Care have the right to complain and file a grievance about any aspect of the services or providers. A complaint may be submitted verbally by calling CMS/Ped-I-Care toll-free at 1-866-376-2456 (ask for Member Services) or locally: 352-334-1706. If a participant complains to the CMS Nurse Care Coordinator, the complaint will be passed on to the Member Services Office of CMS/Ped-I-Care.

If the family complains to the provider about the services received through the CMS/Ped-I-Care system, the provider should provide the toll-free number and encourage the family to let us know how we can improve our services.

If the resolution of the complaint is not satisfactory, or the complaint is egregious, the family may file a grievance. A grievance must be filed in writing. The family may call the Member Services line and the complaint/grievance form will be sent to them with instructions on how to process the form, the time frames and what other remedial steps are available to them. Detailed instructions are contained in the Member Handbook as follows.

Complaints and Grievances

If you are worried about your child's care call Ped-I-Care. Call us if you do not like something that has happened. You can also call us if you want to talk about our program. We will listen to you. We will do our best to make everything better. We will answer all of your questions and issues. Call us at 1-866-376-2456. Ask for Member Services. You can call Monday through Friday from 8:00 am to 7:00 pm. You can also talk to your CMS Nurse about these things.

You can also write to us at:

CMS/Ped-I-Care
1701 SW 16th Avenue, Building A
Gainesville, FL 32608

You have the right to talk to us about any issues you are having. We must answer you. We will call you within 5 days of hearing from you. We will also write to you. A copy of the letter will be sent to your CMS Nurse too.

If Member Services cannot answer your question, we will find someone who can. We will tell you if this happens. We will work with the Quality Improvement Manager if it is a health issue. We will work with the Network Manager if it is an issue with a doctor or nurse.

You can send us a grievance if you do not like the answer that we give to you. A grievance is when you tell us how unhappy you are with what has happened. You must tell us this within a year of when the problem happened. You can make a grievance in writing or by talking to us.

You can file a grievance about many things. You can make one about a doctor you do not like. You can make one about what we can or cannot do for you in the program. You can make one about whether you were allowed or not allowed to make a visit to a doctor. Or you can make one about the program itself.

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Call Ped-I-Care at 1-866-376-2456. Ask for Member Services. Tell them that you want to file a grievance over the phone. Or you can tell them to send you a grievance form and you can make it in writing. We will send you a form in the mail within 3 days. We can help you fill out this form too. Call 1-866-376-2456. Ask for Member Services. Ped-I-Care will send you a letter in the mail to tell you when we get your grievance.

We will read your grievance in the Grievance Committee. We will do this within 15 days of getting your grievance. We have many people on our Committee. They include the:

- Executive Director of CMS/Ped-I-Care
- Medical Director or Associate Medical Director of CMS/Ped-I-Care
- Grievance Coordinator
- CMS Medical Director
- CMS Area Office Nursing Supervisor
- CMS Family Advocate
- CMS/Ped-I-Care Member Services Manager and/or Network Manager and/or Quality Improvement Manager (It will depend on the issue of your grievance)
- Risk Management Representative
- Doctor or nurse who understands the problem

We will put together all the facts about the grievance. This may include health records. It may also include a meeting with the doctor or nurse who is part of the grievance. It may be a meeting with the family. It may also include written letters. We will work with the Quality Improvement manager if it is a health issue. We will work with the Network manager if it is an issue with a doctor or nurse.

We will tell you as soon as we have set up a day and time for a meeting. We will call you within one day of setting up the meeting. You can come and bring your family, a friend, a doctor, or nurse.

After the meeting, we will decide if anything needs to be done to make things better. We will send you a letter in the mail to tell you what we are going to do about your grievance. If we need to make a decision faster than that, we will try to do that.

If you are not happy with what we have done about the grievance then you can meet with the Grievance Committee. This is when you can tell us more about the grievance. Your doctor can also do this if he/she is not happy with the answer. After we meet, the Committee will send you a letter to tell you what we are doing.

We will tell you what we are doing with your grievance. We will also use it to try and make our program better. A grievance will not affect what we can do for you or your doctor.

We can mail you more information about how to file a grievance. Call us at 1-866-376-2456. Ask for Member Services. You can also talk to your nurse about these things. Or you can write to us at:

CMS/Ped-I-Care
1701 SW 16th Avenue, Building A
Gainesville, FL 32608

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Beneficiary Assistance Program/Medicaid Fair Hearing

If you were not happy with how we handled your grievance, you can write or call the Medicaid Beneficiary Assistance Program (BAP). The address and phone number are:

Medicaid Beneficiary Assistance Program
2727 Mahan Drive, Fort Knox # 1, Mail Stop 26
Tallahassee, FL 32308
Telephone Number: 1-888-419-3456 (toll free) or 850-921-5458

You can use this program if you are unhappy with how we handled your grievance. You need to talk to them within one year of hearing back from the Grievance Committee. You can ask to continue with our program until we have answered your grievance. But, you may have to pay for any visits you made if we find that we answered your grievance the right way.

1. You must send your grievance in writing to CMS/Ped-I-Care
2. You must talk to the Beneficiary Assistance Program within one year after when the grievance happened
3. You can make a grievance if you are worried about the care you are getting. You can make a grievance if you are unhappy with our relationship.

Another thing you can do is ask for a Medicaid Fair Hearing. You may request a Medicaid fair hearing after you hear from CMS/Ped-I-Care about your grievance.

A doctor, if you give him/her permission, may help you request a Medicaid Fair Hearing.

You or your doctor may ask for a Medicaid Fair Hearing within ninety (90) days after hearing from CMS/Ped-I-Care. You or your doctor may request a Medicaid Fair Hearing by contacting Division of Children and Families at:

The Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, Florida 32399-0700

You can choose to do one of these two things—you cannot do both. Ped-I-Care will continue to see your child or children during the time your grievance or hearings are taking place.

X. QUALITY IMPROVEMENT PROGRAM

The University of Florida (UF) has accepted the responsibility of providing quality health care to Children with Special Health Care Needs (CSHCN). It is the intention of UF to continually improve the quality of services provided to CMS/Ped-I-Care members. Achieving this goal requires establishing standards and performance goals for the delivery of care, measuring performance outcomes, and initiating appropriate interventions to improve the system of care and health related outcomes.

In order to ensure services meet the community standard and to discover ways the system can be improved, CMS/Ped-I-Care has developed a Quality Improvement Program (QIP). The QIP functions under the supervision of the Quality and Utilization Management Committee (QUMC), composed mainly of physicians who have special training and expertise in Pediatrics.

The complete plan is available upon written request, but is summarized in this section. Certain quality criteria have been identified for providers who participate in the CMS/Ped-I-Care Network. These include credentialing of providers and use of additional provider contracting requirements, which ensure member access and quality care. PCP requirements include access standards for patients, including taking call and scheduling of timely appointments. Requirements related to medical records, confidentiality and patient treatment are included in all contracts and/or this manual.

CMS/Ped-I-Care evaluates the following quality indicators:

1. Access to appropriate care - including wait times for scheduling appointments and in-office waiting time, as well as access to primary care physicians through an after hours call system
2. Mortality
3. Health status indicators:
 - a. Immunization (percent of members at age two (2) years who have completed the basic immunization series)
 - b. Well-child health care utilization (percent of children who are in compliance with the supervision standards established in the guidelines for Health Supervision of Children and Youth developed by the American Academy of Pediatrics)
 - c. Other health care services utilization
4. Family requests for reassignment of Primary Care Physicians
5. Member or family perspectives of care, including complaints and grievances
6. Percent of members or families who report positive perceptions of care

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7. Personnel/provider satisfaction including turn-over rates, physician disenrollment, and satisfaction with payment and authorization systems
8. Compliance with medical record documentation requirements (outlined in Section XI)

Outcome indicators and sources of information used to measure them have been identified. A CMS/Ped-I-Care Quality Improvement Nurse reviews medical records of network providers at least once every two years. Data from claims, as well as patient and provider satisfaction surveys also are reviewed.

In addition to this data driven approach to quality, CMS/Ped-I-Care has developed indicators that, when identified, indicate a need for an individual case review of the circumstances and contributing factors. Events that trigger an individualized chart review include conditions such as hospital admission for diabetic coma, bleeding/perforation or intestinal gangrene.

Providers have their CMS/Ped-I-Care charts reviewed every two years (every year for Behavioral Health) and receive feedback summarizing the review of these charts. The chart reviews are completed using a tool developed from the guidelines for medical records in the Provider Manual. Quality Improvement site visits are scheduled in advance at the convenience of the provider. The site visit includes a survey of the facility to ensure the practice employs appropriate safety, access and confidentiality measures. In addition, providers receive annual reports on the quality outcomes for the CMS/Ped-I-Care program as a whole.

XI. MEDICAL RECORD REQUIREMENTS

Medical Records Requirements for Primary Care Physicians:

1. Each record must contain identifying information on the member, including name, address and phone number, member identification number, date of birth and sex, and legal guardianship.
2. Each record must be legible and maintained in detail.
3. Each record must contain a summary of medical problems, illnesses, significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medications.
4. All entries in each record must be dated and signed.
5. All entries in each record must include the name and profession of practitioner rendering services, for example: M.D., D.O., or O.D., including signature or initials of practitioner.
6. All entries in each record must be legible and indicate the chief complaint or purpose of the visit, the objective findings of practitioner, diagnosis or medical impression.
7. Working diagnoses must be consistent with findings.
8. All entries in each record must indicate appropriate studies as ordered, for example: lab, X-Ray, EKG, and referrals.
9. All entries in each record must indicate therapies administered and prescribed.
10. Treatment plans must be consistent with diagnoses.
11. All entries in each record must include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up, and outcome of services.
12. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
13. Unresolved problems from previous office visits are addressed in subsequent visits.
14. The history and physical examination must identify appropriate subjective and objective information pertinent to the patient's presenting complaints.
15. Each record must contain an immunization history.
16. Each record must contain a record of emergency care and hospital discharge summaries.
17. All records must contain information relating to the Member's use of tobacco products and alcohol/substance abuse if age-appropriate.

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18. All referral services should be documented in the Member's medical record.
19. All services provided by providers should be documented in the record. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases.
20. All records must reflect the primary language spoken by the Member and any translation needs of the Member.
21. All records must identify Members needing communication assistance in the delivery of health care services.
22. All records must contain documentation that the Member (if age 18 or over) was provided written information concerning the Member's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the Member has executed an advance directive.

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Medical Records Requirements for Specialty Providers:

1. Each record must contain identifying information on the member, including name, address and phone number, member identification number, date of birth and sex, and legal guardianship.
2. Each record must be legible and maintained in detail.
3. Each record must contain a summary of medical problems, illnesses, significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medications.
4. All entries in each record must be dated and signed.
5. All entries in each record must include the name and profession of practitioner rendering services, for example: M.D., D.O., or O.D., including signature or initials of practitioner.
6. All entries in each record must be legible and indicate the chief complaint or purpose of the visit, the objective findings of practitioner, diagnosis or medical impression.
7. Working diagnoses must be consistent with findings.
8. All entries in each record must indicate appropriate studies as ordered, for example: lab, X-Ray, EKG, and referrals.
9. All entries in each record must indicate therapies administered and prescribed.
10. Treatment plans must be consistent with diagnoses.
11. All entries in each record must include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up, and outcome of services.
12. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
13. Unresolved problems from previous office visits are addressed in subsequent visits.
14. The history and physical examination must identify appropriate subjective and objective information pertinent to the patient's presenting complaints.

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Medical Records Requirements for Ancillary Providers:

1. Each record must contain identifying information on the member, including name, address and phone number, member identification number, date of birth and sex, and legal guardianship.
2. Each record must be legible and maintained in detail.
3. Each record must contain a summary of medical problems, illnesses, significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medications.
4. All entries in each record must be dated and signed.
5. All entries in each record must include the name and profession of provider rendering services including signature or initials of provider.
6. All entries in each record must be legible and indicate the chief complaint or purpose of the visit, the objective findings of practitioner, diagnosis or medical impression.
7. Working diagnoses must be consistent with findings.
8. All entries in each record must indicate therapies administered and prescribed.
9. Treatment plans must be consistent with diagnoses.
10. All entries in each record must include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up, and outcome of services.
11. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
12. Unresolved problems from previous office visits are addressed in subsequent visits.

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Medical Records Requirements for Hospital Providers:

1. Each record must contain identifying information on the member, including name, address and phone number, member identification number, date of birth and sex, and legal guardianship.
2. Each record must be legible and maintained in detail.
3. Each record must contain a summary of medical problems, illnesses, significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medications.
4. All entries must be dated and signed.
5. All entries must include the name and profession of practitioner rendering services, for example: M.D., D.O., or O.D., including signature or initials of practitioner.
6. All entries must be legible and indicate the chief complaint or purpose of the visit, the objective findings of practitioner, diagnosis or medical impression.
7. Working diagnoses must be consistent with findings.
8. All entries must indicate appropriate studies as ordered, for example: lab, X-Ray, EKG, and referrals.
9. All entries must indicate therapies administered and prescribed.
10. Treatment plans must be consistent with diagnoses.
11. All entries must include the disposition, recommendations, instructions to the member, and outcome of services.
12. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits.
13. The history and physical examination must identify appropriate subjective and objective information pertinent to the patient's presenting complaints.
14. Each record must contain a discharge summary and a record of the discharge plan.

XII. DENTAL SERVICES

Dental services are a covered benefit under the CMS/Ped-I-Care Program. Referrals and authorizations are not necessary for routine dental care. An authorization is needed for an initial evaluation for orthodontia and for orthodontia. A treatment plan will need to accompany the request for authorization.

To request an authorization for orthodontia, please send request, treatment plan and clinical notes documenting medical necessity to MED3000. Also, the request must include the Medicaid Orthodontic Initial Assessment Form (IAF), which may be found in the Dental Services Coverage and Limitations Handbook. Note: Orthodontia for cosmetic purposes is not an approved benefit under CMS/Ped-I-Care. Medical necessity must be documented.

Dental claims should be filed on an ADA Dental Claim Form and mailed to:

University of Florida CMS/Ped-I-Care
P.O. Box 10885
Pensacola, FL 32524

XIII. TRANSPORTATION

Transportation is a covered benefit under the CMS/Ped-I-Care PSN. Emergency and non-emergency transportation is covered. The contracted provider for **non-emergency** transportation services is TMS of Florida.

Members should call TMS of Florida at 1-866-867-0729 to arrange for transportation to appointments with providers. Members should give 72 hours notice when scheduling transportation for routine appointments. TMS may also be contacted to provide transportation if a member is sick. Every effort will be made to provide transportation with minimal notice in these situations.

For members who are dependent on a ventilator or otherwise too medically complex for transport by TMS, please call Century Ambulance Service at 800-771-2829 (toll free) or 904-356-2828.

XIV. BEHAVIORAL HEALTH SERVICES

CMS/Ped-I-Care provides a full range of medically necessary behavioral health services for all members. The following services are covered:

1. Inpatient hospital care for psychiatric conditions (ICD-9-CM codes 290 through 290.43, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
2. Outpatient hospital care for psychiatric conditions (ICD-9-CM codes 290 through 290.43, 293 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
3. Psychiatric physician services (for psychiatric specialty codes 42, 43, 44 and ICD-9-CM codes 290 through 290.43, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
4. Community mental health services (ICD-9-CM codes 290 through 290.43, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9); and for these procedure codes H0001, H0001HN; H0001H0, H0001TS; H0031; H0031 HO; H0031HN; H0031TS; H0032; H0032TS; H0046; H0047; H2000; H2000HO; H2000HP; H2010HO; H2010HE; H2010HF; H2010HQ; H2012; H2012HF; H2017; H2019; H2019HM; M2019HN; H2019HO; H2019HQ; H2019HR; H2030; T1007; T1007TS; T1015; T1015HE; T1015HF; T1023HE; or T1023HF;
5. Mental Health Targeted Case Management (Children: T1017HA; Adults: T1017); and
6. Mental Health Intensive Targeted Case Management (Adults: T1017HK).

Non-Covered Services

The following services are not covered by CMS/Ped-I-Care. Should CMS/Ped-I-Care determine the need for, or be advised of the need for, these or other services not customarily covered by CMS/Ped-I-Care, CMS/Ped-I-Care shall refer the Member to the appropriate provider:

1. Specialized Therapeutic Foster Care
2. Therapeutic Group Care Services
3. Behavioral Health Overlay Service;
4. Community Substance Abuse Services, except as required by CMS/Ped-I-Care's contract with AHCA
5. Residential Care
6. Sub-acute Inpatient Psychiatric Program (SIPP) Services

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7. Clubhouse Services
8. Comprehensive Behavioral Assessment
9. Florida Assertive Community Treatment Services (FACT)

CMS/Ped-I-Care is NOT responsible for the provision of mental health services to members assigned to a FACT team by the DCF Substance Abuse and Mental Health Program (SAMH) Office. These individuals will be disenrolled from the plan and receive all mental health services through the funding mechanism developed by DCF/SAMH and AHCA and re-enrolled in the plan upon discharge from the FACT Team Services. The FACT Team providers are responsible for notifying Medicaid of admissions and discharges.

Services available under CMS/Ped-I-Care represent a comprehensive range of appropriate services for both Children/Adolescents and young adults who experience impairments ranging from mild to severe and persistent. The following is a description of the services offered:

1. Inpatient Hospital Services

Inpatient Hospital services are medically necessary mental health care services provided in a hospital setting. Services may be provided in a general Hospital psychiatric unit or in a specialty Hospital. The inpatient care and treatment services that a Member receives must be under the direction of a licensed physician with the appropriate Medicaid specialty requirements.

- a. A hospital's per diem (daily rate) for inpatient mental health hospital care and treatment covers all services and items furnished during a 24-hour period. The facilities, supplies, appliances, and equipment furnished by the hospital during the inpatient stay are included in the per diem as well as the related nursing, social, and other services furnished by the hospital during the inpatient stay.
- b. For all Child/Adolescent Members, CMS/Ped-I-Care is responsible for the provision of up to 365 days of mental health-related Hospital inpatient care for each year.
- c. If a Member is admitted to a Hospital for a non-psychiatric diagnosis and during the same hospitalization transfers to a psychiatric unit or the treatment of a psychiatric diagnosis, CMS/Ped-I-Care will cover the Medically Necessary mental health treatment inpatient days up to the maximum number of days.
- d. CMS/Ped-I-Care is responsible for covering the cost of all Members' Medically Necessary stays resulting from a mental health emergency, until such time as Members can be safely transported to a designated facility.
- e. Crisis Stabilization Units may be used as a downward substitution for inpatient psychiatric hospital care when determined medically appropriate. They are calculated on a two for one basis. Two CSU days count toward one inpatient day. Beds funded by the Department of Children and Families (DCF), Substance Abuse and Mental Health (SAMH) cannot be used for Members if there are non-

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funded clients in need of the beds. If CSU beds are at capacity, and some of the beds are occupied by Members, and a non-funded client presents in need of services, the Members must be transferred to an appropriate facility to allow the admission of the non-funded client.

2. Outpatient Hospital Services

Outpatient Hospital services are Medically Necessary mental health care services provided in a hospital setting. The outpatient care and treatment services that a Member receives must be under the direction of a licensed physician with the appropriate specialty.

3. Physician Services

- a. Physician services are those services rendered by a licensed physician who possesses the appropriate Medicaid specialty requirements when applicable. A psychiatrist must be certified as a psychiatrist by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or have completed a psychiatry residency accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada.
- b. Physician services include specialty consultations for evaluations. A physician consultation shall include an examination and evaluation of the Member with information from family member(s) or significant others as appropriate. The consultation shall include written documentation of an exchange of information with the attending Provider. The components of the evaluation and management procedure code and diagnosis code must be documented in the Member's medical record. A Hospital visit to a Member in an acute care Hospital for a mental health diagnosis must be documented with a mental health procedure code and mental health diagnosis code. All procedures with a minimum time requirement shall be documented in the medical record to show the time spent providing the service to the Member. CMS/Ped-I-Care will be responsive to requests for consultations made by the PCP.
- c. Physicians are required to coordinate Medically Necessary mental health care with the PCP and other Providers involved with the care of the Member. CMS Nurse Care Coordinators (NCCs) will assist with the coordination of care.

4. Community Mental Health Services – Covered Services

a. General Provisions

Community mental health services include mental health services that are provided for the maximum reduction of the Member's mental health disability and restoration to the best possible functional level. Community mental health services can reasonably be expected to improve the Member's condition or prevent further regression so that the services will no longer be needed. CMS/Ped-I-Care covers services that are medically necessary and are rendered or

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recommended by a physician, psychiatrist, or licensed mental health professional and included in an individualized treatment plan. Medically Necessary community mental health services will be provided to Members of all ages from very young children through age 20 years. Provision of services very early may reduce the provision of expensive services later. Services should be age appropriate and sensitive to the developmental level of the member.

The services provided must meet the intent of the services covered in the Florida Medicaid Community Mental Health Services Coverage and Limitations Handbook. The following describes basic categories of mental health care services considered core services. The frequency, duration, and content of the services should be consistent with the age, developmental level and level of functioning of the member.

i. Treatment Plan Development and Modification

Treatment plan development and modification includes “treatment plan development” and “treatment plan review.” Treatment planning includes working with the Member, their natural support system, and all involved treating Providers to develop an individualized plan for addressing identified clinical needs. A Behavioral Health Care Provider must complete a face-to-face interview with the Member during the development of the plan.

The Individualized Treatment Plan shall:

- be recovery-oriented and promote resiliency;
- be member-directed;
- accurately reflect the presenting problems of the member;
- be based on the strengths of the member, family, and other natural support systems;
- provide outcome-oriented objectives for the member;
- include an outcome-oriented schedule of services that will be provided to meet the member’s needs; and
- include the coordination of services not covered by the plan such as school-based services, vocational rehabilitation, housing supports, Medicaid fee-for-service substance abuse treatment, and physical health care.

Individualized Treatment Plan reviews shall be conducted at six month intervals to ensure that the services being provided are effective and remain appropriate for addressing individual needs. Additionally, a review is expected whenever clinically significant events occur. The provider is expected to use the Individualized Treatment Plan review process in the utilization management of medically necessary services. For further guidance see the most recent Community Behavioral Health Services and Coverage Handbook available on the Medicaid web site.

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ii. Assessment Services

- These services include psychological testing (standardized tests) and evaluations that assess the member's functioning in all areas. All evaluations must be appropriate to the age, developmental level and functioning of the member. All evaluations must include a clinical summary that integrates all the information gathered and identifies member's needs. The evaluation should prioritize the clinical needs, evaluate the effectiveness of any prior treatment, and include recommendations for interventions and services to be provided.
- Evaluation or assessment services, when determined medically necessary, must include assessment of mental status, functional capacity, strengths, and service needs by trained mental health staff. Also included in this category is the administration of the functional assessments that are required by AHCA for Healthcare Administration (AHCA), Division of Children and Families (DCF), the External Quality Review Organization (EQRO), or academic research center.
- Prior to receiving any community mental health services, children ages 0-5 must have a current assessment (within one year) of presenting symptoms and behaviors; developmental and medical history; family psychosocial and medical history; assessment of family functioning; a clinical interview with the primary caretaker and an observation of the child's interaction with the caretaker; and an observation of the child's language, cognitive, sensory, motor, self-care, and social functioning.

iii. Medical and Psychiatric Services

- These services include Medically Necessary interventions that require the skills and expertise of a psychiatrist, psychiatric ARNP, or physician.
- Medical interventions include the prescribing and management of medications, individual or group medical psychotherapy, psychiatric evaluation, psychiatric review of treatment records for diagnostic purposes, and psychiatric consultation with a member's family or significant others, primary care providers, and other treatment providers.
- Interventions related to specimen collections, taking vital signs and administering injections are also a covered service.
- These services are distinguished from the physician services outlined above in that they are provided through a community mental health center. Psychiatric or physician services will be available at sites where substantial amounts of community mental health services are provided.

iv. Behavioral Health Therapy Services:

- These services include individual and family therapy, group therapy, and behavioral health day services. These services include psychotherapy or supportive counseling focused on assisting members with the problems or

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symptoms identified in an assessment. The focus should be on identifying and utilizing the strengths of the member, family, and other natural support systems. Therapy services should be geared to the individual needs of the member and should be sensitive to the age, developmental level, and functional level of the member.

- Family or marital therapy is also included in this category. Examples of interventions include those that focus on resolution of a life crisis or an adjustment reaction to an external stressor or developmental challenge.
- Behavioral Day Services are designed to enable individuals to function successfully in the community in the least restrictive environment and to restore or enhance ability for social and prevocational life management services. The primary functions of behavioral health day services are stabilization of the symptoms related to a behavioral health disorder to reduce or eliminate the need for more intensive levels of care, to provide transitional treatment after an acute episode, or to provide a level of therapeutic intensity not possible in a traditional outpatient setting.

v. Community Support and Rehabilitative Services

- These services include: Psychosocial Rehabilitation Services and Clubhouse services. Clubhouse services are excluded from CMS/Ped-I-Care's covered services. Psychosocial rehabilitation services may be provided in a facility, home, or community setting. These services assist members in functioning within the limits of a disability or disabilities resulting from a mental illness. Services focus on restoration of a previous level of functioning or improving the level of functioning. Services must be individualized and directly related to goals for improving functioning within a major life domain.
- The coverage must include a range of social, educational, vocational, behavioral, and cognitive interventions to improve members' potential for social relationships, occupational/educational achievement and living skills development. Skills training development is also included in this category and includes activities aimed toward restoration of members' skills/abilities that are essential for managing their illness, actively participating in treatment, and conducting the requirements of daily independent living. Providers must offer the services in a setting best suited for desired outcomes, i.e., home or community-based settings.

vi. Therapeutic Behavioral On-Site Services for Children and Adolescents (TBOS):

- Therapeutic Behavioral On-Site Services are community services and natural supports for children with serious emotional disturbances. Clinical services include the provision of a professional level therapeutic service that may include the teaching of problem solving skills, behavioral strategies, normalization activities and other treatment modalities that are determined to be medically necessary. These services should be designed

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to maximize strengths and reduce behavior problems or functional deficits stemming from the existence of a mental health disorder. Social services include interventions designed for the restoration, modification, and maintenance of social, personal adjustment and basic living skills.

- These services are intended to maintain the child in the home and to prevent reliance upon a more intensive, restrictive, and costly mental health placement. They are also focused on helping the child possess the physical, emotional, and intellectual skills to live, learn and work in their own communities. Coverage must include the provision of these services outside of the traditional office setting. The services must be provided where they are needed, in the home, school, childcare centers or other community sites.

vii. Services for Children Ages 0 through 5 Years

- Services to these children include behavioral health day services and Therapeutic Behavioral On-Site Services for Children Ages 0 through 5 years.
- Prior to receiving these services, the children in this age group must meet the criteria as stated in the Medicaid Community Behavioral Health Service Coverage and Limitations Handbook.

viii. Crisis Intervention Mental Health Services and Post-Stabilization Care Services

- Crisis intervention services include intervention activities of less than 24-hour duration (within a 24-hour period) designed to stabilize an individual in a Psychiatric emergency.
- Post-stabilization care services include any of the mandatory services that a treating physician views as medically necessary, that are provided after an member is stabilized from an emergency mental health condition in order to maintain the stabilized condition, or under the circumstances described in Federal Regulations 42 CFR 438.114(e) to improve or resolve the member's condition.

ix. Substance Abuse Services

- CMS/Ped-I-Care Members may receive substance abuse services. CMS Nurse Care Coordinators will coordinate and integrate mental health and substance abuse services for plan members. CMS/Ped-I-Care uses the Florida Supplement to the American Society of Addictions Medicine Patient Placement Criteria for the coordination of mental health treatment with substance abuse providers as part of the integration effort (Second Edition ASAM PPC-2, July 1998). The coordination shall be reflected in

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their individualized Treatment Plan for members with co-occurring disorder. The protocol for integrating mental health services with substance abuse services will be monitored through the Quality of Care monitoring activities completed by CMS/Ped-I-Care's EQRO contractor and the Quality Improvement Program.

5. Mental Health Targeted Case Management

- a. CMS/Ped-I-Care provides targeted Case Management services to Children/Adolescents with serious emotional disturbances. CMS/Ped-I-Care shall meet the intent of the services as outlined below and in the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook. CMS/Ped-I-Care has set criteria and clinical guidelines for Case Management services.

At a minimum, case management services are to incorporate the principles of a strengths-based approach. Strengths-based case management services are an alternative service modality for working with individuals and families. This method stresses building on the strengths of individuals that can be used to resolve current problems and issues, countering more traditional approaches that focus almost exclusively on individuals' deficits or needs.

b. Target Populations:

- i. CMS/Ped-I-Care, through its provider network, has Case Management services available to Children/Adolescents who have a serious emotional disturbance as defined as:
 - A Child/Adolescent with a defined mental disorder
 - A level of functioning which requires two or more coordinated mental health services to be able to live in the community
 - Be at imminent risk of out of home mental health treatment placement
- ii. Mental health targeted Case Management services shall be available to all Members within the principles and guidelines described as follows:
 - Members who require numerous services from different providers and also require advocacy and coordination to implement or access services are appropriate for Case Management services;
 - Members who would be unable to access or maintain consistent care within the service delivery system without Case Management services are appropriate for the service;
 - Members who do not possess the strengths, skills, or support system to allow them to access or coordinate services are appropriate for Case Management services;
 - Members without the skills or knowledge necessary to access services may benefit from Case Management. Case Management provides support

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in gaining skills and knowledge needed to access services and enhances the Enrollee's level of independence.

c. Mental Health Targeted Case Management Services

- i. Mental Health Targeted Case Management services include working with the member and the member's natural support system to develop and promote an individualized, needs assessment-based service plan, as described in the Mental Health Targeted Case Management Coverage and Limitations Handbook. The service plan reflects the services or supports needed to meet the needs identified in an individualized assessment of the following areas: education or employment, physical health, mental health, substance abuse, social skills, independent living skills, and support system status. The approach used should identify and utilize the strengths, abilities, cultural characteristics, and informal supports of the member, family, and other natural support systems.

Targeted case managers focus on overcoming barriers by collaborating and coordinating with other service providers and the member to assist in the attainment of service plan goals. The targeted case manager takes the lead in both coordinating services/treatment and assessing the effectiveness of services provided. A strengths-based approach to providing services is consistent with the values of individuality and uniqueness and promotes participant self-direction and choice. The planning process is vital to achieving desired outcomes for the individual. The person must have a sense of ownership about his/her goals, and the goals must have true meaning and vitality for him/her.

- ii. When targeted case management recipients enrolled in CMS/Ped-I-Care are hospitalized in an acute care setting or held in a county jail or juvenile detention facility, the health plan shall maintain contact with the individual and shall participate actively in the discharge planning processes.
- iii. Case managers are also responsible for coordination and collaboration with the parents or guardians of children who receive mental health targeted case management services. The health plan, through the CMS Nurse Care Coordinators will make reasonable efforts to ensure that case managers, include in collaboration the parents or guardians of children in the process of providing targeted case management services. Integration of the parents' input and involvement with the case manager and other providers shall be reflected in clinical record documentation and monitored through the health plan's quality of care monitoring activities. Involvement with the child's school and/or childcare center must also be a component of case management with children.

d. Additional Requirements for Case Management

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- i. Caseloads are set by network providers to achieve the desired results. Ratios are consistent with the requirements set forth in the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.
- ii. Clinical guidelines address issues related to recovery/resiliency, self-care, and family involvement, including services that will assist members in gaining independence from the mental health and case management system.
- iii. The case management program has services available based on the individual needs of the members receiving the service. The service reflects a flexible system that allows movement within an array of services that address the changing needs and abilities of members.
- iv. Case management staff have expertise and training necessary to competently and promptly assist members in working with Social Security Administration or Disability Determination in maintaining benefits from SSI and SSDI. For clients who wish to work, case management staff have the expertise and training necessary to assist members to access Social Security Work Incentives including development of Plans for Achieving Self-Support (PASS).
- v. Case management services incorporate the principles of a strengths-based approach. Strengths-based case management services are a preferred service modality for work with individuals and families. This method stresses building on the strengths of individuals and families that can be used to resolve current problems and issues. This approach counters more traditional approaches that focus almost exclusively on individuals' deficits or needs. Service limits and criteria developed cannot be more restrictive than those in Medicaid policy.

Community Services for Medicaid Recipients Involved with the Corrections System

CMS/Ped-I-Care provides Medically Necessary community-based services for health plan Members who have corrections involvement as follows:

1. CMS/Ped-I-Care has established a linkage to pre-booking sites for assessment, screening or diversion related to mental health services;
2. Provides immediate access (within twenty-four (24) hours of release) for psychiatric services upon release from jail, prison, juvenile detention facility, or other corrections facility to ensure that prescribed medications are available for all Members.
3. CMS/Ped-I-Care has established a linkage to post-booking sites for discharge planning and assuring that prior health plan Members receive necessary services upon release from the facility. CMS/Ped-I-Care Members will be linked to services and receive routine care within seven (7) days from the date they are released.

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4. Provides outreach to homeless and other populations of health plan Members at risk of corrections involvement, as well as those health plan Members currently involved in this system, to ensure that services are accessible and provided when necessary. This activity is oriented toward preventive measures to assess mental health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or corrections system.
5. CMS/Ped-I-Care has developed a cooperative agreement with corrections facilities to enable the health plan to anticipate Members who were CMS/Ped-I-Care Members prior to incarceration who will be released from these institutions. All Members who were health plan Members prior to incarceration and Medicaid Recipients who are likely to enroll in the health plan upon return to the community receive a community mental health service within twenty-four (24) hours of discharge from the corrections facility.

Treatment and Coordination of Care for Members with Medically Complex Conditions

CMS/Ped-I-Care ensures that there are appropriate treatment resources available to address the treatment of complex conditions that reflect both mental health and physical health involvement. The following conditions are specifically addressed:

1. Mental health disorders due to or involving a general medical condition, specifically ICD-9-CM Diagnoses 293.0 through 294.1, 294.9, 307.89, and 310.1.
2. Eating disorders – ICD-9-CM Diagnoses 307.1, 307.50, 307.51, and 307.52.

CMS/Ped-I-Care provides medically necessary community mental health services to members who exhibit the above diagnoses and shall develop a plan of care that includes all appropriate collateral providers necessary to address the complex medical issues involved. Clinical care criteria addresses modalities of treatment that are effective for each diagnosis. CMS/Ped-I-Care's provider network includes appropriate treatment resources necessary for effective treatment of each diagnosis within the required access time periods.

Monitoring of Members admitted to Children's Residential Treatment (Level I – IV)

CMS/Ped-I-Care maintains contact with children who are disenrolled from CMS/Ped-I-Care due to placement in a residential treatment facility. CMS/Ped-I-Care through its concurrent review process, participates in discharge planning, assists the Member and his/her caregiver to locate community-based services, and notifies Medicaid when the Member is discharged from the facility.

Upon notification of the Member's discharge from the facility CMS/Ped-I-Care shall notify the Choice Counselor/Enrollment Broker for re-enrollment into CMS/Ped-I-Care, if it is within 6 months (180 days) from the disenrollment.

Evaluation and Treatment Services for Enrolled Children/Adolescents

1. CMS/Ped-I-Care provides all Medically Necessary evaluation and treatment services for Children/Adolescents referred to CMS/Ped-I-Care by Department of Children and

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Families (DCF), Department of Juvenile Justice (DJJ) and by schools (elementary, middle, and secondary schools).

2. CMS/Ped-I-Care provides Medically Necessary Children/Adolescent mental health services in such a way as to minimize disruption of services available to high-risk populations served by DCF.
3. CMS/Ped-I-Care promptly evaluates, provides psychological testing, and delivers mental health services to Children/Adolescents (including delinquent and dependent Children/Adolescents) referred by DCF in accordance with Medical Necessity. As well, CMS/Ped-I-Care adheres to the minimum staffing, availability and access standards described in this Contract.
4. CMS/Ped-I-Care provides court ordered evaluation and treatment required for Children/Adolescents who are Members.
5. CMS/Ped-I-Care participates in all DCF or school staffings that may result in the provision of mental health services to an enrolled Child/Adolescent.
6. CMS/Ped-I-Care refers Children/Adolescents to DCF when residential treatment is Medically Necessary. CMS/Ped-I-Care is not responsible for providing any residential treatment for Children/Adolescents. The DCF, Substance Abuse and Mental Health ("SAMH") or DJJ District office shall coordinate the placement of the enrolled Child/Adolescent with CMS/Ped-I-Care.
7. CMS/Ped-I-Care's Case Management of Children/Adolescents includes those persons, schools, programs, networks and agencies that figure importantly in the Child's/Adolescent's life.
8. CMS/Ped-I-Care, through its subcontractors, makes determinations about care based on a comprehensive evaluation, consultation with those persons, schools, programs, networks and agencies that figure importantly in the Child's/Adolescent's life, and appropriate protocols for admission and retention.
 - CMS/Ped-I-Care monitors services for adequacy in conformity with the cooperative agreement between CMS/Ped-I-Care and the facility.

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Psychiatric Evaluations for Members Applying for Nursing Home Admission

CMS/Ped-I-Care shall, upon request from the Substance Abuse and Mental Health (SAMH) Offices, promptly arrange for and authorize psychiatric evaluations for members who are applying for admission to a nursing facility pursuant to OBRA 1987, and who, on the basis of a screening conducted by Comprehensive Assessment and Review for Long Term Care (CARES) workers, are thought to need mental health treatment.

The examination shall be adequate to determine the need for “specialized treatment” under the Act. Evaluations must be completed within five working days from the time the request from the DCF SAMH Program Office is received. State regulations have been interpreted by the state to permit any of the “mental health professionals” listed in Section 394.455, Florida Statutes, to make the observations preparatory to the evaluation, although a psychiatrist must sign such evaluations. The vendor will not be responsible for resident reviews or for providing services as a result of a Pre-Admission Screening and Resident Review (PASRR) evaluation.

Crisis Support/Emergency Services

CMS/Ped-I-Care shall operate, under contract to Child Guidance Center, as part of its Crisis Support/Emergency Services, a crisis emergency hotline available to all Members twenty-four (24) hours a day, seven (7) days a week. This hotline may be accessed by calling 904-448-4700.

Provision of Behavioral Health Services When Not Covered by CMS/Ped-I-Care

1. If CMS/Ped-I-Care determines that a Member is in need of behavioral health services that are not covered under the Contract, CMS/Ped-I-Care will refer the Member to the appropriate provider. CMS/Ped-I-Care may request the assistance of the Medicaid local field office or the local DCF District ADM Office for referral to the appropriate service setting.
2. Long-term care institutional services in a nursing facility, an institution for persons with developmental disabilities, specialized therapeutic foster care, children's residential treatment services or State Hospital services are not covered by CMS/Ped-I-Care. For Members requiring those services, CMS/Ped-I-Care will consult the Medicaid Field Office and/or the DCF District ADM Office to identify appropriate methods of assessment and referral.
3. CMS/Ped-I-Care is responsible for transition and referral of the Member to appropriate providers. CMS/Ped-I-Care will request Disenrollment of all Members receiving the services described in this Section, Provision of Behavioral Health Care Services When Not Covered by CMS/Ped-I-Care.

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Behavioral Health Services Care Coordination and Management

CMS/Ped-I-Care is responsible for the coordination and management of Behavioral Health Services and continuity of care for all Members. In order meet these goals CMS/Ped-I-Care will do the following:

1. Minimize disruption to the Member as a result of any change in behavioral health care providers or behavioral health care case managers that occur as a result of Medicaid Reform. For new Members who had been receiving Behavioral Health Services, CMS/Ped-I-Care shall continue to authorize all valid claims for services until CMS/Ped-I-Care has:
 - a. Reviewed the Member's treatment plan;
 - b. Developed an appropriate written transition plan; and
 - c. Implemented the written transition plan.
2. If the previous behavioral health care provider is unable to allow CMS/Ped-I-Care access to the Member's Medical Records because the Member refuses to release his/her records, then CMS/Ped-I-Care shall provide:
 - a. Up to four (4) sessions of individual or group therapy;
 - b. One (1) psychiatric medical session;
 - c. Two (2) one-hour intensive therapeutic sessions on-site; or
 - d. Six (6) days of day treatment services.
3. Document all Emergency Behavioral Health Services received by a Member, along with any follow-up services, in the Member's behavioral health Medical Records. CMS/Ped-I-Care shall also ensure the PCP receives the information about the Emergency Behavioral Health Services for filing in the PCP's Medical Record.
4. Document all referral services in the Member's behavioral health Medical Records.
5. Coordinate Hospital and institutional discharge planning for psychiatric admissions and substance abuse detoxification to ensure inclusion of appropriate post-discharge care.
 - a. Members admitted to an acute care facility (inpatient Hospital or crisis stabilization unit) shall receive appropriate services upon discharge from the acute care facility.
 - b. CMS/Ped-I-Care will have follow-up services available to Members within twenty-four (24) hours of discharge from an acute care facility, provided the acute care facility notified CMS/Ped-I-Care that it had provided services to the Member.

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- c. CMS/Ped-I-Care will continue the medication prescribed by a State mental health facility to the Member for at least ninety (90) days after the State mental health facility discharges the Member, unless CMS/Ped-I-Care 's prescribing psychiatrist, in consultation and agreement with the State mental health facility's prescribing physician, determines that the medications:
 - i. Are not Medically Necessary; or
 - ii. Are potentially harmful to the Member.
6. Provide appropriate referral of the Member for non-covered services to the appropriate service setting. CMS/Ped-I-Care will request referral assistance, as needed, from the Medicaid Field Office. CMS/Ped-I-Care will use the Florida Supplement to the American Society of Addictions Medicine Placement Criteria for coordination and treatment of substance-related disorders with substance abuse Providers. CMS/Ped-I-Care will provide coordination of care with community-based substance abuse agencies as part of its policies and procedures developed for continuity of care for Members who are diagnosed with mental illness and substance abuse or dependency.
7. Provide court ordered mental health evaluations for Members. CMS/Ped-I-Care providers shall also provide expert behavioral health testimony for Members.
8. Provide appropriate screening, assessment, and crisis intervention in support for Members who are in the care and custody of the State.

CMS/Ped-I-Care shall participate in the SAMH planning process in each DCF district.

1. CMS/Ped-I-Care has a Drug Utilization Review ("DUR") program. Once CMS/Ped-I-Care's pharmacy utilization indicates that a Member is receiving an antipsychotic medication from a PCP or prescribing non-psychiatrist physician, CMS/Ped-I-Care shall request a consultation with the PCP or prescribing non-psychiatrist physician.
2. Once CMS/Ped-I-Care's pharmacy utilization indicates that an Member, who is being treated by a Behavioral Health Care Provider, receives medication for certain physical conditions (such as hypertension, diabetes, neurological disorders, cardiac problems, or any other serious medical condition) CMS/Ped-I-Care shall schedule a consultation with the PCP or prescribing physician to discuss coordination of care and concerns related to drug interactions.
3. CMS/Ped-I-Care shall ensure coordination with the PCP or prescribing physician with regards to drug utilization and potential contraindications.

Discharge Planning

Discharge Planning is the evaluation of a Member's medical care needs, including mental health service needs, substance abuse service needs, or both, in order to arrange for appropriate care after discharge from one level of care to another level of care. CMS/Ped-I-Care will, through its TPA:

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1. Monitor all Member discharge plans from behavioral health inpatient admissions to ensure that they incorporate the Members' needs for continuity in existing behavioral health therapeutic relationships.
2. Ensure that Members' family members, guardians, outpatient individual practitioners and other identified supports are given the opportunity to participate in Member treatment to the maximum extent practicable and appropriate, including behavioral health treatment team meetings and developing the discharge plan.
3. Designate staff members who are responsible for identifying Members who remain in the Hospital for non-clinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk Members and Members with multiple agency involvement).
4. Develop and implement a plan that monitors and ensures that clinically indicated Behavioral Health Services are offered and available to Members within twenty-four (24) hours of discharge from an inpatient setting.
5. Ensure that a behavioral health program clinician provides medication management to Members requiring medication monitoring within twenty-four (24) hours of discharge from a behavioral health program inpatient setting. CMS/Ped-I-Care shall ensure that the behavioral health program clinician is duly qualified and licensed to provide medication management.
6. Upon the admission of a Member, CMS/Ped-I-Care shall make its best efforts to ensure the Member's smooth transition to the next service or to the community; and shall require that Behavioral Health Care Providers:
 - a. Assign a case manager to oversee the care given to the Member;
 - b. Develop an individualized discharge plan, in collaboration with the Member where appropriate, for the next service or program or the Member's discharge, anticipating the Member's movement along a continuum of services; and
 - c. Make best efforts to ensure a smooth transition to the next service or community;
 - d. Document all significant efforts related to these activities, including the Member's active participation in discharge planning.

Transition Plan

A transition plan is a detailed description of the process of transferring Members from providers to CMS/Ped-I-Care's Behavioral Health Care Provider network to ensure optimal continuity of care. The transition plan shall include, but not be limited to, a timeline for transferring Members, description of provider medical record transfers, scheduling of appointments, proposing prescription drug protocols and claims approval for existing providers during the transition period. CMS/Ped-I-Care shall document its efforts relating to the transition plan.

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1. CMS/Ped-I-Care shall minimize the disruption of treatment by a Member's current behavioral health care provider by arranging for Member use of services outside of CMS/Ped-I-Care's network. For Members who have received Behavioral Health Services for at least six (6) months from a behavioral health care provider, whether the provider is in CMS/Ped-I-Care's network or not, CMS/Ped-I-Care shall continue to authorize all valid claims until CMS/Ped-I-Care reviews the Member's treatment plan and implements an appropriate written transition plan.
2. During the first three (3) months that the Member receives Behavioral Health Services under this Contract, CMS/Ped-I-Care shall not deny requests for Behavioral Health Services outside the network under the following conditions:
 - a. The Member is a patient at a community behavioral health center and the center has discussed the Member's care with CMS/Ped-I-Care.
 - b. If, following contact with CMS/Ped-I-Care, there is no Behavioral Health Care Provider readily available and the Member's condition would not permit a delay in treatment.
3. If the previous treating Provider is unable to allow CMS/Ped-I-Care access to the Member's Medical Records because the Member refuses to release the records, then CMS/Ped-I-Care shall approve the provider's claims for:
 - a. Four (4) sessions of outpatient behavioral health counseling or therapy;
 - b. One (1) outpatient psychiatric physician session;
 - c. Two (2) one-hour intensive therapeutic on-site sessions; or
 - d. Six (6) days of day treatment services.
4. Any disputes related to coverage of services necessary for the transition of Members from their current behavioral health care provider to another behavioral health care provider shall follow the process set forth in Section VIII, Grievance Process, of this Manual.
5. CMS/Ped-I-Care will approve claims from providers for authorized out-of-plan non-emergency services, provided such claims are submitted within twelve (12) months of the date of service.

Functional Assessment

1. CMS/Ped-I-Care shall ensure that all Behavioral Health Care Providers administer functional assessments using the Functional Assessment Rating Scales (FARS) for all Members over the age of eighteen (18) and Child Functional Assessment Rating Scale (CFARS) for all Members age eighteen (18) and under.
2. CMS/Ped-I-Care shall ensure that all Behavioral Health Care Providers administer and maintain the FARS and CFARS according to the FARS and CFARS manuals to all

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Members receiving Behavioral Health Services and upon termination of providing such services.

3. The results of the FARS and CFARS assessments shall be maintained in each Member's medical record, including a chart trending the results of the functional assessments.
4. CMS/Ped-I-Care shall submit the FARS/CFARS reports as required.

Outreach Program

CMS/Ped-I-Care has an outreach program designed to encourage Members to seek Behavioral Health Services through CMS/Ped-I-Care when CMS/Ped-I-Care, or Providers, perceive a need for Behavioral Health Services. In addition, the outreach program provides for the following:

1. Outreach program Member communications that are written at the fourth (4th) grade reading level;
2. Outreach program communications that are written in the primary language spoken by the Member;
3. A program designed to assist PCPs in the identification and management, including referral and other resources, to aid in the treatment of:
 - a. Members with severe and persistent mental illness;
 - b. Children/Adolescents with severe emotional disturbances;
 - c. Members with clinical depression; and
4. A program to identify and manage Members who are homeless.

Behavioral Health Managed Care Local Advisory Group

There will be an advisory group for CMS/Ped-I-Care that convenes quarterly and reports to AHCA on advocacy and programmatic concerns. The local advisory group is responsible for providing technical and policy advice to AHCA regarding CMS/Ped-I-Care's provision of services. The local advisory group does not have access to Member Medical Records.

CMS/Ped-I-Care's responsibility related to the advisory group is as follows:

1. Ensure representation at all scheduled meetings;
2. Provide information requested by advisory group members;
3. Follow up on identified issues of concern related to the provision of services or administration of CMS/Ped-I-Care; and
4. Share pertinent information about Quality Improvement findings and outreach activities with the group.

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Appointment Waiting Times and Geographic Access Standards

CMS/Ped-I-Cares must ensure that PCP services and referrals to Participating Specialists are available on a timely basis, as follows:

1. Urgent Care — within one (1) day;
2. Routine Sick Patient Care — within one (1) week; and
3. Well Care Visit — within one (1) month.

Behavioral Health Services

1. CMS/Ped-I-Care shall have at least one (1) certified adult psychiatrist and at least one (1) board certified child psychiatrist (or one (1) child psychiatrist who meets all education and training criteria for Board Certification) that are available within thirty (30) minutes average travel time for Urban areas and sixty (60) minutes average travel time for Rural areas of all Members.
2. For Rural areas, if CMS/Ped-I-Care does not have a Provider with the necessary experience, AHCA may waive, in writing, the requirements above.
3. CMS/Ped-I-Care shall ensure that outpatient staff includes at least one (1) FTE Direct Service Behavioral Health Provider per 1,500 Members. AHCA expects CMS/Ped-I-Care's staffing pattern for direct service Providers to reflect the ethnic and racial composition of the community.
4. CMS/Ped-I-Care's array of Direct Service Behavioral Health Providers for children/Adolescents shall include Providers that are licensed or eligible for licensure, and demonstrate two (2) years of clinical experience in the following specialty areas or with the following populations:
 - a. Adoption;
 - b. Child protection or foster care;
 - c. Dual diagnosis (mental illness and substance abuse);
 - d. Dual diagnosis (mental illness and developmental disability);
 - e. Developmental disabilities;
 - f. Behavior analysis;
 - g. Behavior management and alternative therapies for Children/Adolescents;
 - h. Separation and loss;

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- i. Victims and perpetrators of sexual abuse (Children/Adolescents and adults);
 - j. Victims and perpetrators of violence and violent crimes (Children/Adolescents and adults);
 - k. Court ordered mental health evaluations including assessment of parental mental health issues and parental competency as it relates to mental health; and
 - l. Expert witness testimony.
5. All Direct Service Behavioral Health Providers and mental health targeted case managers serving the Children/Adolescent population shall be certified by DCF to administer CFARS (or other rating scale required by DCF or AHCA).
 6. Mental health targeted case managers shall not be counted as Direct Service Behavioral Health Providers.
 7. For Case Management services, CMS/Ped-I-Care, through its contracted provider network shall provide staff that meets the following minimum requirements:
 - a. Have a baccalaureate degree from an accredited university, with major course work in the areas of psychology, social work, health education or a related human service field and, if working with Children/Adolescents, have a minimum of one- (1) year full time experience or equivalent experience, working with the target population, or
 - b. Have a baccalaureate degree from an accredited university and if working with Children/Adolescents, have at least three (3) years full time or equivalent experience, working with the target population. (Note: case managers who were certified by the Department prior to July 1, 1999, who do not meet the degree requirements, may provide Case Management services if they meet the other requirements); and
 - c. Have completed a training program within six (6) months of employment. The training program must be prior approved by AHCA. The training must include a review of the local resources and a thorough presentation of the applicable State and federal statutes and promote the knowledge, skills, and competency of all case managers through the presentation of key core elements relevant to the target population. The case manager must also be able to demonstrate an understanding of CMS/Ped-I-Care's Case Management policies and procedures.
 8. Case Management supervision must be provided by a person who has a master's degree in a human services field and three (3) years of professional full time experience serving this target population or a person with a bachelor's degree and five (5) years of full time or equivalent Case Management experience. For supervising case managers who work only with adults, two (2) years of full time experience is required. The supervisors must have had the approved health plan training in Case Management or have documentation that they have prior equivalent training.

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9. CMS/Ped-I-Care shall have access to no less than one (1) fully accredited psychiatric community Hospital bed per 2,000 Members, as appropriate for both Children/Adolescents and adults. Specialty psychiatric Hospital beds may be used to count toward this requirement when psychiatric community Hospital beds are not available within a particular community. Additionally, CMS/Ped-I-Care shall have access to sufficient numbers of accredited Hospital beds on a medical/surgical unit to meet the need for medical detoxification treatment.
10. CMS/Ped-I-Care's facilities must be licensed, as required by law and rule, accessible to the handicapped, in compliance with federal Americans with Disabilities Act guidelines, and have adequate space, supplies, good sanitation, and fire, safety, and disaster preparedness and recovery procedures in operation.
11. CMS/Ped-I-Care shall ensure that it has Providers that are qualified to serve Members and experienced in serving severely emotionally disturbed Children/Adolescents. CMS/Ped-I-Care, through CMS Program Office, shall maintain documentation of its Providers' experience in the Providers' credentialing file.
12. CMS/Ped-I-Care, through its contract with Child Guidance Center, shall adhere to the staffing ratio of at least one (1) FTE Behavioral Health Care Case Manager for twenty (20) Children/Adolescents. Direct Service Behavioral Health Care Providers shall not count as Behavioral Health Care Case Managers.
13. CMS/Ped-I-Care shall request current behavioral health care provider information from all new Members upon enrollment. CMS/Ped-I-Care shall solicit these behavioral health services providers to participate in CMS/Ped-I-Care's network. CMS/Ped-I-Care may request in writing that AHCA grant exemption to a health plan from soliciting a specific behavioral health services provider on a case-by-case basis.

Behavioral Health QI Requirements

1. CMS/Ped-I-Care's Quality Improvement Program (QIP) includes a Behavioral Health component in order to monitor and ensure that CMS/Ped-I-Care's Behavioral Health Services are sufficient in quantity, of acceptable quality and meet the needs of the Members.
2. Treatment plans must:
 - a. Identify reasonable and appropriate objectives;
 - b. Provide necessary services to meet the identified objectives; and
 - c. Include retrospective reviews that confirm that the care provided, and its outcomes, were consistent with the approved treatment plans and appropriate for the Member's needs.
3. In determining if Behavioral Health Services are acceptable according to current treatment standards, CMS/Ped-I-Care shall:

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4. Perform a quarterly review of a random selection of ten percent (10%) or fifty (50) medical records, whichever is more, of Members who received Behavioral Health Services during the previous quarter; and
5. Elements of these reviews shall include, but not be limited to:
 - i. Management of specific diagnoses;
 - ii. Appropriateness and timeliness of care;
 - iii. Comprehensiveness of and compliance with CMS/Ped-I-Care plan of care;
 - iv. Evidence of special screening for high risk Members and/or conditions; and
 - v. Evidence of appropriate coordination of care.

Performance Measures (PMs)

CMS/Ped-I-Care shall collect data on patient outcome PMs, as defined by the Health Plan Employer Data and Information Set (HEDIS) or otherwise defined by AHCA, and report the results of the measures to AHCA annually. AHCA may add or remove reporting requirements with 30 days advance notice.

Utilization Management (Behavioral Health Specific) General Requirements

The Utilization Management (UM) program includes, but is not limited to:

1. Procedures for identifying patterns of over-utilization and under-utilization by Members and for addressing potential problems identified as a result of these analyses.
2. Service Authorization protocols for Prior Authorization and denial of services; the process used to evaluate prior and concurrent authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting Provider when appropriate, Hospital discharge planning, physician profiling; and a retrospective review of both inpatient and ambulatory claims, meeting the predefined criteria below. CMS/Ped-I-Care shall be responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting Provider when appropriate.
 - a. CMS/Ped-I-Care's Service Authorization system provides the authorization number and effective dates for authorization to Participating Providers and non-participating Providers.
 - b. Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for Behavioral Health Services. The psychiatrist's review shall be part of the UM process and not part of the clinical review, which may be requested by a Provider or the Member, after the issuance of a denial.

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Behavioral Health Staff Requirements

1. CMS/Ped-I-Care has named a staff member to maintain oversight responsibility for Behavioral Health Services and to act as a liaison to AHCA. This person is Martin Lazoritz, M.D.
2. CMS/Ped-I-Care's Medical Director has appointed a board certified, or board eligible, licensed psychiatrist (staff psychiatrist) to oversee the provision of Behavioral Health Services to Enrollees. This physician is Martin Lazoritz M.D.

Medical Records Requirements (Behavioral Health Specific)

CMS/Ped-I-Care providers shall maintain a behavioral health Medical Record for each Enrollee. Each Enrollee's behavioral health Medical Record shall include:

1. Documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of Behavioral Health Services performed;
2. Must be legible and maintained in detail consistent with the clinical and professional practice which facilitates effective internal and external purity, medical audit and adequate follow-up treatment; and
3. For each service provided, clear identification as to:
 - a. The physician or other service provider;
 - b. Date of service;
 - c. The units of service provided; and
 - d. The type of service provided.

XV. CONTRACT DEFINITIONS

AHCA – The State of Florida’s Agency for Health Care Administration

Behavioral Health Managed Care Advisory Group – A group comprised of providers, recipient representatives, advocacy groups, representatives from the Pre-paid Mental Health Plan (PMHP) vendor, representatives of the Health Maintenance Organizations, the Department of Children and Families, local Agency representatives, and other relevant groups as identified by AHCA that convenes quarterly. The role of the advisory group is to provide a forum for discussion of issues related to the local behavioral health treatment community. The advisory group should communicate technical or policy advice to the Agency related to managed mental health care plans and share best practices with other local providers to improve the quality of care rendered to all recipients of publicly-funded health care services.

Children’s Medical Services (CMS) – A program of the State of Florida Department of Health, authorized by Chapter 391 Florida Statutes. The mission of CMS is to champion the delivery of health care to children with special health care needs and to provide specialized services to children with special health care needs as well as to those children who have been abused or neglected.

Children with Special Health Care Needs – Children under age twenty-one (21) years whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children. Health care utilization by these children exceeds the statistically expected usage of the normal child adjusted for chronological age. These children often need complex care requiring multiple providers, rehabilitation services, and specialized equipment in a number of different settings. (Sections 391.021 and 409.811, F.S.)

CMS Program – The program administered by CMS, designed to provide comprehensive health care coverage to Florida children with special health care needs.

Covered Benefit – Any medical or health related service for which payment is made by the ICS (CMS/Ped-I-Care) or Florida Medicaid to the provider of such services.

Cultural Competency – The concept of cultural competency is one based on the definitions and principles developed by the national Child and Adolescent Service System Program (CASSP). Cultural Competence is a set of congruent practice skills, behaviors, attitudes, and policies that comes together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. As defined by the CASSP, culture is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs.

DCF – The State of Florida’s Department of Children and Families.

DJJ – The State of Florida’s Department of Juvenile Justice.

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Emergency Care – Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital (Section 641.47, F.S.)

Emergency Mental Health Condition – A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in placing the health of the individual in serious jeopardy.

Emergency Mental Health Services – Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is at a level of severity that would meet the requirements for involuntary examination pursuant to Section 394.463, Florida Statutes, and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

External Quality Review (EQR) – The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that are furnished to Medicaid recipients by a managed care entity.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in Federal Regulations 42 CFR 438.354, and performs external quality review, other EQRO-related activities as set forth in federal regulations or both.

Family Centered Care – A partnership formed with children with special health care needs and their families, the primary care providers, CMS care coordinators and the ICS staff so that the questions, concerns and needs of these children and their families are integrated into the delivery of health care services they receive.

Florida Mental Health Act – Chapter 394, Florida Statutes, including the Baker Act, which covers involuntary admissions for persons who are considered to be in an emergency mental health condition.

Grievance Procedure – A written protocol and procedure detailing an organized process by which members or ICS network providers may express dissatisfaction with care, goods, services or benefits received and the resolution of these dissatisfactions. This procedure is established by the ICS and approved by CMS and AHCA.

Health Care Entity – A hospital, facility, or ancillary services provider that is organized and licensed in and by the State of Florida to provide medical or health related services and/or supplies, as allowed by applicable State and Federal laws, and may include, but is not limited to, licensed general acute care hospitals, psychiatric hospitals, rehabilitation hospitals, and ancillary facilities or services, including ambulatory surgical centers, diagnostic centers, radiation oncology centers, retail pharmacies, laboratories, home health offices, skilled nursing facilities and nursing homes, birthing centers, hospice facilities, and durable medical equipment suppliers.

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Health Care Professional – Any health care practitioner, other than a physician, or physician extender who is licensed, certified, or otherwise authorized in or by the State of Florida to independently (i.e., not subject to the supervision of another) provide health related services in his/her designated area of practice, profession, or discipline.

Hospital – An acute care hospital, licensed under Chapter 395, Florida Statutes

Integrated Care System (ICS) – A comprehensive contracted program of services for children with special health care needs. This is the core service delivery structure of the Children’s Medical Services Network (CMSN). The ICS for the contract with CMS is a division of the University of Florida College of Medicine Department of Pediatrics (University). The ICS is also known as CMS/Ped-I-Care.

Licensed Practitioner of the Healing Arts – A psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

Medicaid – The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C.s. 1396 et seq., and regulations there under, as administered in this state by the Agency under s. 409.901 et seq., F.S.

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 member’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 member, the member’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.

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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.

Member – A CMS child assigned by the state to receive services through the ICS (CMS/Ped-I-Care). Any eligible Medicaid recipient enrolled in the PSN. Also referred to as “enrollee.”

Mental Health Care Professional – Any of the mental health professionals, as listed in Section 394.455, Florida Statutes, or a registered nurse, licensed under Chapter 464, Florida Statutes, and qualified due to training or competency in mental health care, who is responsible for the provision of mental health care to patients.

Mental Health Targeted Case Manager – An individual who provides mental health case management services directly to or on behalf of an enrollee on an individual basis, in accordance with the Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.

Participating Provider(s) – Those physicians or health care professionals who, through contracts with the University, have agreed to participate and provide medical and/or health related services to members and such participating provider’s physician extenders accepted by the University.

Physician – A medical doctor or doctor of osteopathy who is licensed to practice in the State of Florida.

Physician Extender – An individual who is licensed, certified, or otherwise authorized in or by the State of Florida to provide health related services in his/her designated area of practice, profession, or discipline, subject to the supervision of a physician, i.e., an Advanced Registered Nurse Practitioner (ARNP), Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), or Certified Nurse Midwife (CNM).

PSN – Provider Service Network

Provider – Refers to the health care entity, named in the preamble of providers’ contracts with ICS. If health care entity employs physicians, health care professionals, all references to “Health Care Entity” or “Provider” and Health Care Entity’s or Provider’s obligations, shall apply, as applicable, to Health Care Entity’s or Provider’s staff Physicians, Health Care Professionals.

SAMH Office – The Substance Abuse and Mental Health Office of the Department of Children and Families (formerly known as ADM).

TANF – Temporary Assistance to Needy Families – public financial assistance provided to low-income families.

Targeted Case Management Services – Services that will assist Medicaid eligible individuals in gaining access to needed medical, social, educational, or other services.

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Third Party Administrator (TPA) – A vendor operating under contract with University to process/pay claims for authorized services provided to members and to provide other administrative and management services.

Urgent Care – Those services needed to relieve pain or distress for medical conditions that, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or do substantially restrict a member's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.). Those services needed to immediately relieve pain or distress for medical problems.

XVI. RESPONSIBILITIES OF PROVIDER and UNIVERSITY (CMS/Ped-I-Care) COVENANTS and TERMS

RESPONSIBILITIES OF PROVIDER

Notification of Change In Status

Subject to extenuating circumstances beyond Provider's reasonable control, Provider shall immediately verbally notify University via CMS/Ped-I-Care's Executive Director if Provider is involved in or aware of any act, event, or occurrence which materially affects Provider's ability to carry out duties and obligations under the contract with CMS/Ped-I-Care, including, but not limited to, suspension or loss of license, loss of hospital privileges, loss of professional liability coverage, exclusion from participation in Medicare, Medicaid, or other federal health care programs (eligible providers), conviction of a felony, or incapacity to perform the essential functions of the contract with CMS/Ped-I-Care, with or without accommodation. Provider's verbal notification shall be confirmed in writing, and sent to University to CMS/Ped-I-Care, Attn: Executive Director, 1701 SW 16th Avenue, Bldg. A, Gainesville, FL 32608, within three (3) business days of such verbal notification.

Specialty Care

The Specialty Provider shall provide specialty care services to children with special health care needs and their siblings who are enrolled in CMS/Ped-I-Care (Members). For each Member seen by Provider, Provider shall generate a medical record in compliance with medical record requirements set forth in Section XI of this manual. The Provider shall provide health care services in a family-centered manner to Members. Elements of family-centered care include:

Whenever possible, medical care for all children in a family is by same provider.

1. Inclusion of family input in development of treatment plans
2. Collaboration with the CMS Nurse Care Coordinator who will assist the PCP and specialty provider in maintaining family contact, and assess medical and psychosocial matters and will coordinate services, and provide education, and anticipatory guidance. Collaboration includes providing copies of chart notes to the CMS Nurse Care Coordinator.

Medical Home

Provider shall provide specialty services to Members within the context of a Medical Home that includes:

1. Continuity of care, including participation in a process that promotes coordination of care and information flow between the PCP, specialists and the family

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2. Provision of services in a timely fashion; referrals will be seen within no more than thirty (30) calendar days from date referral is made
3. In-office wait times for scheduled appointments shall not exceed forty-five (45) minutes

Provider Training

Provider agrees to attend, or send an appropriate representative to, CMS/Ped-I-Care provider training on billing and CMS/Ped-I-Care policies. Once Provider or his/her appropriate representative has attended the noted training, Provider shall be responsible to follow all billing procedures.

Grievance Procedures

Provider must follow the Grievance Procedure for CMS/Ped-I-Care providers, established by CMS/Ped-I-Care for processing complaints the Provider may have against CMS/Ped-I-Care. Provider shall comply with, and subject to rights of appeal, shall be bound by such grievance procedure. Upon request, Provider shall make available to Members, their families, or their legal representative the Grievance Procedure for Members, established by CMS/Ped-I-Care, for processing any Member complaint regarding Covered Benefits furnished by Provider. Grievance procedures are described in the Provider Manual, Section VIII.

Notice of Malpractice Actions

Provider shall advise CMS/Ped-I-Care of each malpractice claim filed against Provider or any physician associated with Provider and each settlement or judgment of malpractice claim entered into by Provider or an associated physician within fifteen (15) business days following said filing, settlement or judgment.

Medical Record Retention

Provider shall maintain with respect to each Member receiving Covered Benefits a single standard medical record in such form, containing such information, and preserved for **not less than five (5) years from termination of the provider Agreement, and, if the records are under review or audit, until such audit or review is concluded.** Provider shall not dispose of any medical record pertaining to a Member receiving Covered Benefits without the prior approval of ICS. To the extent permitted by law, in accordance with procedures required by law, Provider shall permit CMS/Ped-I-Care to inspect and make copies of said records at no charge, and shall provide copies of such records to CMS/Ped-I-Care upon request.

Compliance with Florida and Federal Statutes

Provider agrees to cooperate with CMS/Ped-I-Care so that CMS/Ped-I-Care may meet any requirements imposed by state and federal law, as amended, and all regulations issued pursuant thereto. Provider agrees to maintain such records and provide such information to CMS/Ped-I-Care, or to applicable state and federal regulatory agencies for compliance, as may be required. Such obligations shall not be terminated upon termination of the contract with CMS/Ped-I-Care. Provider agrees to permit CMS/Ped-I-Care, or CMS/Ped-I-Care's authorized representative and

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funding entities, at all reasonable times to have access upon request to books, records and other papers related to Covered Benefits rendered by Provider. Provider agrees to retain such records for a term of at least five (5) years from and after the termination of the contract with CMS/Ped-I-Care. Provider further agrees to permit access to, and inspection by CMS/Ped-I-Care, the Florida Department of Insurance, the United States Department of Health and Human Services, and the Comptroller General of the United States, at all reasonable times and upon demand, of all those facilities, books and records maintained or utilized by Providers in performance of Covered Benefits pursuant to the contract with CMS/Ped-I-Care.

Malpractice Insurance

Providers licensed as physicians pursuant to Chapter 458, Florida Statutes, and those licensed as osteopathic physicians pursuant to Chapter 459, Florida Statutes, shall maintain, at their sole cost and expense and throughout the entire term that the Provider is participating in the CMS/Ped-I-Care Network, financial responsibility as set forth in s. 458.320 (1) or (2), Florida Statutes and s. 459.0085 (1) or (2), Florida Statutes respectively. Hospital providers shall be insured to the standard of the Hospital industry.

Workers' Compensation Insurance

Provider agrees to provide, at Provider's sole cost and expense, workers' compensation insurance for Provider's agents, servants, and employees throughout the entire term that the Provider is participating in the CMS/Ped-I-Care Network, in accordance with the laws of the State of Florida as the same may from time to time be amended.

Comprehensive Insurance

Provider shall provide, at Provider's sole cost and expense, throughout the entire term that the Provider is participating in the CMS/Ped-I-Care Network, a policy or policies of insurance covering Provider's principal place of business against any claim of loss, liability or damage committed to or arising out of the alleged condition of said premises, or the furniture, equipment, etc.

Substitute Coverage

During Provider's temporary absence or unavailability, Provider shall arrange for an appropriate substitute to provide Covered Benefits to Members under Provider's care. Provider shall use best efforts to make such arrangements with other CMS/Ped-I-Care participating providers, in compliance with CMS Program policies and procedures, and applicable State and Federal laws, rules, and regulations.

Member Medical Records

Upon termination of the contract with CMS/Ped-I-Care, Provider agrees to cooperate with Members, CMS and/or CMS/Ped-I-Care, and subsequent providers, with respect to the orderly and prompt transfer of copies of a Member's medical records.

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Cultural Competency Plan

CMS/Ped-I-Care has a comprehensive written Cultural Competency Plan that will ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency. The Cultural Competency Plan describes how the Providers, CMS/Ped-I-Care employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individual Members and protects and preserves the dignity of each. Provider shall comply with all provisions of the CMS/Ped-I-Care Cultural Competency Plan while providing services pursuant to this Agreement.

If you would like to request a free copy of the full CMS/Ped-I-Care Cultural Competency Plan, please contact Provider Relations at 866-376-2456. You may also find a copy of the complete plan on the Ped-I-Care web site at pedicare.peds.ufl.edu.

Non-Discrimination

Provider agrees: (i) not to differentiate or discriminate in its provision of services to Enrollees because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, disability or age, and (ii) to render services to Enrollees in the same manner, in accordance with the same standards as offered to patients who are not Enrollees consistent with existing medical ethical/legal requirements for providing continuity of care to any patient.

RESPONSIBILITIES OF UNIVERSITY (CMS/Ped-I-Care)

Provider Listing

Once the contract with CMS/Ped-I-Care is fully executed by the legal representative of each party and contingent on full credentialing of Provider, University, through CMS/Ped-I-Care, shall list the Provider as an authorized CMS/Ped-I-Care Provider and shall make payments to Provider, through the TPA, as specified in the contract. Payment is contingent upon continued funding under the contract between the University of Florida and the State of Florida, Department of Health, Children's Medical Services. Should funds for this contract become unavailable, CMS/Ped-I-Care will provide written notice to Provider.

Education/Training

University, through CMS/Ped-I-Care, shall inform and educate Members and their families about their responsibilities and about the role of the primary care physician in providing primary care and authorizing the services provided by the specialist.

Professional Training and Assistance

University, through CMS/Ped-I-Care, shall be responsible for the following:

1. Provision of training and technical assistance to Provider on billing and program policies
2. Submission of reports to Provider regarding utilization of services and achievement of CMS/Ped-I-Care performance measures

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Courtesy Faculty Appointments

All CMS/Ped-I-Care providers are invited to become courtesy members of the faculty of the Department of Pediatrics at the University of Florida. Courtesy Faculty are entitled to receive a Gator1 card, which allows the member to participate in all continuing medical education programs at UF, use all UF library facilities, purchase tickets to sporting events, use faculty parking, and more. To find out more about Gator1 Card benefits go to: http://www.bsd.ufl.edu/IdCard/Gator1C_info.asp. To apply for a Courtesy Faculty appointment, call Elaine Cronheim in the Pediatric Chairman's Office at 352-392-3337.

MISCELLANEOUS TERMS

Notice by Provider of its Withdrawal from CMS/Ped-I-Care Network

Provider agrees to provide advance written notice to CMS/Ped-I-Care of its intent to withdraw from the CMS/Ped-I-Care network at least ninety (90) calendar days prior to the effective date of its termination or withdrawal from the CMS/Ped-I-Care network.

Responsibility for Members at Termination

Except for termination for cause, as specified in CMS/Ped-I-Care Provider Contracts, Provider shall continue to provide Covered Benefits to a Member who is receiving Covered Benefits from Provider on the effective termination date of the CMS/Ped-I-Care Provider Contract until the Covered Benefits being rendered to the Member by Provider are completed (consistent with existing medical ethical/legal requirements for providing continuity of care to a patient), unless CMS/Ped-I-Care makes provision for the assumption of such Covered Benefits by another CMS/Ped-I-Care provider. CMS/Ped-I-Care shall complete the reassignment of Members to another CMS/Ped-I-Care provider within one hundred eighty (180) days, pursuant to CMS/Ped-I-Care policies, following the effective termination date of the CMS/Ped-I-Care Provider Contract. University will compensate Provider for those Covered Benefits provided to a Member pursuant to rates as shown in Attachment 1 of the Provider Contract.

Proprietary Rights

Each party to the contract with CMS/Ped-I-Care reserves the right to control the use of its name, likeness, symbols, trademarks, and service marks, presently existing or hereafter established. Each party agrees that it will not use the other party's name, likeness, symbols, trademarks, or service marks in advertising, promotional materials, or otherwise, without the prior written consent of the other party, and will cease any permitted usage immediately upon termination of the contract with CMS/Ped-I-Care. In addition, each party agrees that any signs, displays, literature, or material furnished by the other party remains the property of the other party, and shall be returned upon demand or the termination of the contract with CMS/Ped-I-Care. Notwithstanding the foregoing, University, CMS/Ped-I-Care, and/or CMS may list Provider's name, location and specialty in any CMS or CMS/Ped-I-Care directory associated with the CMS/Ped-I-Care Provider Contract, unless instructed otherwise by Provider.

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XVII. FRAUD AND ABUSE

CMS/Ped-I-Care actively attempts to prevent and identify suspected incidents of Medicaid fraud and abuse. All activities seen as fraud and/or abuse will be reported to the CMS/Ped-I-Care Compliance Department for investigation and follow-up. Pursuant to Medicaid regulations, in the event of suspected fraud and/or abuse, chart audits may be conducted without prior notice. Incidents may be reported to the Medicaid Office of Program Integrity as appropriate and as needed. CMS/Ped-I-Care proactively, prospectively, and retrospectively analyzes the potential for an occurrence of fraud and abuse, and monitors for fraud and abuse using resources such as (but not limited to) claims, utilization management, quality management, grievance/appeals and random chart audits.

CMS/Ped-I-Care additionally routinely accesses and uses the Health and Human Services (HHS) Office of the Inspector General's List of Excluded Individuals and Entities (LEIE) to identify individuals excluded from participation in Medicaid, and therefore CMS/Ped-I-Care. Confidentiality will be maintained for the suspect person or entity and the person reporting, and all rights afforded to both providers and enrollees will be reserved and enforced during the investigation process. Providers must comply with all aspects of CMS/Ped-I-Care's Compliance Program and its fraud and abuse plan/requirements.

Report suspected fraud and abuse confidentially and without fear of retaliation to:

1. The CMS/Ped-I-Care Compliance Director at (352) 334-4083 or the CMS/Ped-I-Care hotline: 1-866-787-4557
2. The Florida Medicaid Fraud and Abuse Hotline at 1-888-419-3456
3. Medicaid Fraud and Abuse Complaint Form (to report suspected fraud and/or abuse in the Florida Medicaid system) please go to the following Website:
http://ahcaxnet.fdhc.state.fl.us/InspectorGeneral/fraud_complaintform.aspx
 - a. Address for mailing complaint form:
Bureau Chief, Medicaid Program Integrity
2727 Mahan Drive, MS # 6
Tallahassee, Florida 32308
4. by electronic mail to:
http://ahca.myflorida.com/Executive/Inspector_General/medicaid.shtml

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Training materials for the CMS/Ped-I-Care Compliance Plan may be found in the CD that was sent to you with this Provider Manual and on the CMS/Ped-I-Care web site: pedicare.peds.ufl.edu. Please have all members of your staff review the materials and sign the enclosed acknowledgement form. The form may be faxed to CMS/Ped-I-Care at 352-955-6518 or mailed to:

Compliance Director
CMS/Ped-I-Care
1705 SW 16th Avenue, Bldg. A
Gainesville, FL 32608

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Compliance Acknowledgement Form

University of Florida, CMS/Ped-I-Care requires every employee and contracted provider to actively participate in the Medicaid Program Integrity Compliance Plan. The employee's and/or providers' roles and responsibilities, as related to the organization, contribute to the Compliance Program's effectiveness in preventing, detecting, and reporting misconduct.

I have received Ped-I-Care Fraud and Abuse training. I have received, read, understand, and agree to abide by the Medicaid Program Integrity Compliance Plan, Professional Code of Conduct and Ethics Standard and compliance policies and procedures. I agree to comply with the standards contained in the code and all related policies and procedures. I will report any potential violation of which I become aware promptly to my supervisor or the Compliance Director. I understand that any violation of the Code of Conduct or any corporate compliance policy is grounds for disciplinary action, up to and including termination of my employment or contract.

Employee/Contracted Provider (Print)

—

Employee/Contracted Provider (Signature) Date

Mail Originals to:

Compliance Director
UF Pediatric Integrated Care System (Ped-I-Care)
1701 S.W. 16th Avenue, Bldg. A, Room 3214
Gainesville, FL 32608

Fax: 352-955-6518