Title 21 Provider Manual

April 12, 2016

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1. CONTACT INFORMATION

Member Eligibility and Claims Questions

- eINFOsource: https://cms.eINFOsource.MED3000.com, or
- Call MED3OOO Customer Service: (800) 664-0146
  - Hours: Monday – Friday, 8:30 a.m. – 5:30 p.m. EST; or
- Fax (866) 246-2094

Utilization Management Issues:
Authorization of Services, Requests for UM Policies and Procedures

- MED3OOO Medical Department: Phone (800) 492-9634
  - Hours: Monday – Friday, 8:30 a.m. – 5:30 p.m. EST; or
- Fax (866) 256-2015
- After Hours: eINFOsource or call (800) 492-9634 (option #1) for the on-call UM Nurse

To access eINFOsource:

https://cms.eINFOsource.MED3000.com

To sign up for eINFOsource:

MED3OOO Customer Service: (800) 664-0146

To submit your paper claims for Ped-I-Care services:

Mail to: MED3OOO/Ped-I-Care Title 21, PO Box 981733, El Paso, TX 79998

To appeal claims that have been denied or underpaid:

Mail to: Ped-I-Care, University of Florida ICS, 1699 SW 16th Avenue, Gainesville, FL 32608
Attn: Claims Appeals

Fax: (352) 294-8092

To arrange for pharmacy or transportation services:

Contact the CMS Nurse Care Coordinator for the member:

Gainesville CMS:	(352) 334-1400	Ocala CMS:	(352) 369-2100
Daytona Beach CMS:	(386) 238-4980	Jacksonville CMS:	(904) 360-7070
Pensacola CMS:	(850) 484-5040	Viera CMS:	(321) 639-5888
Panama City CMS:	(850) 872-4700	Tampa CMS:	(813) 396-9743
Tallahassee CMS:	(850) 487-2604	Lakeland CMS:	(863) 413-3580
Orlando CMS:	(407) 858-5555	St. Petersburg CMS:	(727) 217-7800

Or call Transportation Management Services of Florida (TMS) at (855) 739-5986

To notify Ped-I-Care of provider/practice changes, address, telephone number, tax ID, etc.:

- Submit in writing:
  Ped-I-Care Provider Relations, 1699 SW 16th Ave, Gainesville, FL 32608
- Fax (352) 294-8081; or
- Call: (866) 376-2456 or (352) 627-9100

To apply for CMS provider approval:

Apply online at: https://www.cmskidsproviders.com

To resolve contracting or procedural questions, or to request staff orientation or education:

- Contact Ped-I-Care Provider Relations, 1699 SW 16th Ave, Gainesville, FL 32608
- Fax (352) 955-6518; or
- Call: (866) 376-2456 or (352) 627-9100

Ped-I-Care Offices

1699 SW 16th Avenue • Gainesville, FL 32608
Phone: (352) 627-9100 • Toll Free: (866) 376-2456 Fax: (352) 955-6518

CMS Plan Area Offices

Daytona Beach Area Office

✓ *Serving Flagler and Volusia Counties*

421 S Keech Street
Daytona Beach, FL 32114-4623
Phone: (386) 238-4980 or (866) 827-5197
Fax: (386) 254-3937

Gainesville Area Office

✓ *Serving Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties*

1701 SW 16th Avenue
Gainesville, FL 32608
Phone: (352) 334-1400
Fax: (352) 334-1389

Jacksonville Area Office

✓ *Serving Baker, Clay, Duval, Nassau, and St. Johns Counties*

910 N Jefferson Street
Jacksonville, FL 32209-6810
Phone: (904) 360-7070 or (800) 340-8354
Fax: (904) 798-4569

Lakeland Area Office

✓ *Serving Hardee, Highlands, and Polk Counties*

200 N Kentucky Avenue, Suite 114
Lakeland, FL 33801
Phone: (863) 413-3580 or (800) 741-2250
Fax: (863) 413-3597

Ocala Area Office

✓ *Serving Orange, Osceola, and Seminole Counties*

3200 E Silver Springs Boulevard, Suite 201
Ocala, FL 34470
Phone: (352) 369-2100 or (888) 326-7485
Fax: (352) 369-2134

Orlando Area Office

✓ *Serving Orange, Osceola, and Seminole Counties*

7000 Lake Ellenor Drive
Orlando, FL 32809
Phone: (407) 858-5555 or (800) 226-6530
Fax: (407) 856-6573

Panama City Area Office

- ✓ *Serving Bay, Calhoun, Gulf, Holmes, Jackson, and Washington Counties*

230 N Tyndall Parkway
Panama City, FL 32404
Phone: (850) 872-4700 or (800) 299-4700
Fax: (850) 872-4817

Pensacola Area Office

- ✓ *Serving Escambia, Okaloosa, Santa Rosa, and Walton Counties*

5192 Bayou Boulevard
Pensacola, FL 32503
Phone: (850) 484-5040 or (800) 484-5040
Fax: (850) 484-5042

St. Petersburg Area Office

- ✓ *Serving Pasco and Pinellas Counties*

3491 Gandy Boulevard, Suite 100
Pinellas Park, FL 33781
Phone: (727) 217-7800 or (800) 336-1612
Fax: (727) 217-7921

Tallahassee Area Office

- ✓ *Serving Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla Counties*

2390 Phillips Road
Tallahassee, FL 32308
Phone: (850) 487-2604 or (800) 226-2604
Fax: (850) 488-8852

Tampa Area Office

- ✓ *Serving Hillsborough County*

13101 N Bruce B. Downs Boulevard
Tampa, FL 33612
Phone: (813) 396-9743 or (866) 300-6878
Fax: (813) 396-9746

Viera Area Office

- ✓ *Serving Brevard County*

2565 Judge Fran Jamieson Way
Viera, FL 32940
Phone: (321) 639-5888
Fax: (321) 690-3887

2. PED-I-CARE: BACKGROUND AND SERVICES

About 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 Florida Department of Health's (FDOH) Children's Medical Services Managed Care Plan (CMS Plan) Division. CMS Plan has designated this contracted service as a Pediatric Integrated Care System (ICS). This ICS is known as Ped-I-Care, and it provides care to children with special health care needs from the age of one year until the child reaches his/her nineteenth birthday. It has been implemented in collaboration with the local CMS Plan 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 meet the legislative mandate that services for children enrolled in State Child Health Insurance Programs (SCHIP) be purchased on a capitated basis and the CMS Plan expectation that this will be accomplished without a loss of quality of care for the enrolled children. The goal, therefore, has been to develop a program that is sensitive and responsive to the special needs of children participating in CMS Plan, and yet functions cost-effectively within a capitated funding environment.

The objectives are to:

- 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;
- Develop and refine the infrastructure needed to receive, manage and account for capitated payments;
- Deliver and coordinate quality primary and specialty care; and
- Evaluate and continually improve the quality of service delivery, including participation in preventive care, such as child 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 Plan in providing services to children with special health care needs. Accepting responsibility for implementing the Pediatric Integrated Care System, 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 exciting opportunity to offer quality care to Florida children.

Network Management

The Ped-I-Care Office staff will assist the providers' offices with policies and procedures related to Ped-I-Care. They will respond to provider requests, questions, and concerns.

Examples of issues with which Ped-I-Care staff can help include:

- Administrative issues: Assistance with billing and claims payment, how to follow up on claim status, notification of changes in the practice;
- Patient related issues: Primary Care Physicians (PCP) who want to change assignment criteria or capacity; and
- Medical Management issues: Clarification on Utilization Management, e.g. benefit limits, how to get services authorized, and quality improvement procedures and reports.

The Ped-I-Care staff will also 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.

The Ped-I-Care staff will contact the PCP's office regularly, but any provider is welcome to call us at any time at (866) 376-2456 or (352) 627-9100.

Member Services

At enrollment into Ped-I-Care, every family will be sent a Member Handbook, Provider Directory, a letter of verification of enrollment and an identification card (see Section 4, p. 12). If the family has not chosen or been assigned to a PCP, instructions on how to select a PCP, and a statement indicating that a new ID card will be sent upon PCP selection will be included with the materials. 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 ([866] 376-2456 or [352] 627-9100).

The role of Member Services is to assist the member/family to obtain needed services and navigate the system with ease. Member Services will assist the provider and CMS Plan with patient-related issues, provide information on covered and non-covered services, educate members/families on Ped-I-Care processes and policies, facilitate member access to services, update enrollee demographic information, accept and track member complaints and grievances, and change PCP assignment at the request of members/families.

If, for any reason, an enrollee wishes to change from the assigned PCP, the enrollee may request a re-assignment by notifying Member Services. The family may change PCPs at any time; the change is effective immediately. The management fee payment is assigned to the PCP based upon who provides services first the month in which the change occurs. The enrollee 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.

Third-Party Administrator

The University of Florida has contracted with a third-party administrator (TPA), MED3OOO, to perform several functions required to operate Ped-I-Care. MED3OOO provides the Management Information System that receives and tracks membership information, processes and pays claims and provides Utilization Management support through the authorization and referral processes. We are pleased that MED3OOO is a member of our team.

3. PROGRAM OVERVIEW

The goal of 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 Plan 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 Ped-I-Care network. Network providers should submit copies of their chart notes to the assigned NCC to facilitate care coordination.

Every participant in 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). PCPs provide access to phone consultation for families 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.

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

- Office wait times should not be longer than 45 minutes.
- PCPs provide well-child care within 4 weeks of the request for service.
- Symptomatic care is provided within 2 weeks of the request and urgent care within 24 hours.
- Specialty evaluation and treatment for a member’s condition is to be provided within 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 Ped-I-Care to expedite an appointment.

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 Ped-I-Care network, Ped-I-Care works with the referring provider to ensure access to needed services for members.

The CMS Plan NCCs assist providers in maintaining the health of children and coordinating medical care. They help to ensure that children and their families 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 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 Ped-I-Care Member Services Office, which works with the provider and the NCC to address and resolve the issue(s).

Coordinating Care

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, 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 should provide copies of chart notes/reports to the NCC when requested by the NCC.

Utilization Management

All Ped-I-Care providers follow the Utilization Management (UM) guidelines summarized in this Provider Manual in Section VI. Primary care services provided by the assigned PCP do not require authorization. The PCP or a specialist may refer a member to specialty services that are needed by the child. Some of the requested services will require authorization through MED3OOO.

> Service coverage and limitations can be found in the Florida Medicaid Provider Handbooks at: http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx.
>
> The Medicaid Summary of Services Manual is found at: http://www.fdhc.state.fl.us/Medicaid/flmedicaid.shtml.

Exceptions to Medicaid's coverage and limitations may exist, please refer to Section 6 of this manual, Ped-I-Care's website, or call MED3OOO at 800-492-9634 (toll-free) if you have any questions.

Requests for service authorizations are handled through MED3OOO according to Medicaid and InterQual® guidelines. You may call (800) 492-9634, fax a request to (866) 256-2015 or go through eINFOsource online for authorizations and notifications.

Use of the Emergency Department

Primary Care Physicians offer on-call services to members 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 interest of the child to wait until the next office day to receive care. If a child is treated in the emergency department, authorizations are not required, but a notification is required. Notifications are submitted to MED3OOO via eINFOsource, by calling (800) 492-9634, or fax to (866) 256-2015 using the Title 21 Referral/Authorization and Notification Form. The PCP 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 Plan NCC, who will contact the family to offer education and support to avoid unnecessary use of the emergency department. 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.

Quality Improvement

Ped-I-Care visits each provider at least once every three years 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 11. The results of the site visit are summarized in a letter sent to the provider. Data related to quality measures of the program are available to participating providers.

Administrative Updates

Providers should notify Ped-I-Care of practice changes in writing or by phone at least 30 days prior to the effective date. Changes can be reported on Ped-I-Care's Provider Group update form: http://pedicare.peds.ufl.edu/members/Group%20Change%20Update%20Form.pdf.

Changes that need to be conveyed to Ped-I-Care include:

- Change of location, mailing address or phone number
- Change in tax ID number
- Change of practice name
- Provider(s) joining or leaving group practice
- Addition/deletion of hospital privileges
- Addition or deletion of service sites

NOTE: Any changes made on or after the 20th of the month that affect the payment of PCP monthly management fees will be effective the first of the month following the next. Changes made prior to the 20th of the month will be reflected the first of the following month.

Pediatric Integrated Care System, 1699 SW 16th Ave, Gainesville, FL 32608-1153 (866) 376-2456

PARTICIPATING GROUP CHANGE/UPDATE FORM

Please complete applicable information and fax back to Ped-I-Care at 352-294-8081.

Today's Date: ______________________ ☐ Remit address change?

Group Name: ______________________ Tax ID: ______________________

Remit Address: ______________________

City, State: __________ Zip: ______ Phone: __________ Fax: __________

Contact Name: ______________________ Email Address: ______________________

Contact Phone: ______________________ AHCA Facility License #: ______________________

Medicaid #: __________ NPI #: __________ Taxonomy #: __________

If a provider is not CMS credentialed, it is important that you submit an application online at https://www.cmskidsproviders.com/eis/

Date CMS on-line credentialing application submitted: ______________________

It is recommended that newly contracted Ped-I-Care Title XIX providers complete fraud and abuse training upon signing and annually thereafter.
The training is located at http://www.pedicare.peds.ufl.edu/compliance/index.html

Please provide the following for each provider. Use additional pages as necessary.

	ADD	DELETE
Provider Name		
Provider Specialty		
Hospitalist?	Yes ☐ No ☐	
Effective Date		
Social Security #		
Gender		
License #		
Medicaid #		
NPI #		
Taxonomy #		
DEA #		
Language(s)		
Facility Name & Location		
Facility NPI #		
Facility Medicaid #		
Facility Hours of Operation		
Phone #		

4. PARTICIPANT ELIGIBILITY, IDENTIFICATION AND ASSIGNMENT

Member Eligibility

Ped-I-Care members are children who are enrolled in CMS Plan because they have special health care needs and are eligible for health insurance through the State Child Health Insurance Program (SCHIP). This is the funding source for "Healthy Kids."

Eligibility begins at the beginning of a month, and continued eligibility is based on the family's payment of a monthly premium. This results in a month-to-month eligibility status. Members are issued an identification (ID) card within a few weeks of their initial enrollment in Ped-I-Care and in the interim have a letter verifying eligibility until they receive their ID card (see sample card on page 12). **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**. Members are eligible from age 12 months until their 19th birthday.

Verification of enrollment in Ped-I-Care can be checked by using eINFOsource, the web-based database available from MED3OOO. Eligibility and PCP assignment will be available on-line to all providers. The initial list of eligible participants will be online by the first day of the month. A late payment of the monthly premium by the family may result in the child not being on the member list until a few days after the month has begun. To gain access to eINFOsource, contact the MED3OOO Customer Service at (800) 664-0146.

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

New Patients

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 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 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 Plan NCC contacts new members. 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.

Members may request to change PCPs. Transfer requests may be initiated by the member or the member's legal guardian. The family may change PCPs at any time however; the effective date of the change will be made the first of the following month. The enrollee 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.

The PCPs determine the number of Ped-I-Care participants they will accept. They also specify any other criteria for accepting patients. When initially enrolled in the 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 Ped-I-Care Provider Relations Office: (352) 627-9100 or (866) 376-2456.

Sample Title 21 Member ID Card

(front)

CMS Title 21

Member Name: «MemFName» «MemLName»
Date of Birth: «DOB» Member ID: «MemID»

PCP Name: «PCPFacName»
PCP Phone: «PCPFacPhone»

CMS Office: «CMSoffice» CMS Phone: «CMSTOLLFRE»

MEMBER SERVICES: (866) 376-2456
Member must present his/her ID card to his/her PCP, hospital or other provider before receiving medical services.

ELIGIBILITY VERIFICATION: eINFOsource (https://PedICare.eINFOsource.Med3000.com/) or call (800) 664-0146.
(This card is not proof of CMS or Ped-I-Care network enrollment.)

Form T21-1a

(back)

Physician or Hospital: Non-emergency admissions require prior authorization.
Contact the MED3000 UM Department: (800) 492-9634.

Emergency services require notification to PCP including notes, labs, and other

ELIGIBILITY VERIFICATION: eINFOsource (https://cms.eINFOsource.Med3000.com) or call (800) 664-0146
(This card is not proof of CMS or Ped-I-Care network enrollment.)

Provider Claims/Customer Service: (800) 664-0146
Utilization Management - Referrals/Authorizations: (800) 492-9634
Claims Address: Children's Medical Services, PO Box 981733 El Paso, TX 79998
(All claims except Pharmacy)

Pharmacy Carrier #10180
Group: CMN01 BIN: 3585
MedImpact Pharmacy Help Desk (800) 788-2949
Transportation: Call TMS/Access2Care (855-739-5986)
24/7 Nurse Help Line-1-844-514-3779

Form T21-1b

This card is to be used by Ped-I-Care patients for all services, including pharmacy benefits.

5. COVERED BENEFITS

The services provided through 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. They can be downloaded from website:
http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx.

Services in the CMS Plan benefits package include:	
Ambulatory Surgical Center Services	Laboratory & X-ray
Behavioral/Mental Health Services	Licensed Midwife Services
Birthing Center Services	Nurse Practitioner (operating with credentialed MD)
Child Health Check-Up Services	Optometric Services
Chiropractic Services	Physician Assistant Services (operating with credentialed MD)
Clinic Services (County Health Department Clinic Services)	Physician Assistant Services
Community Mental Health Services	Podiatry Services
Dental Services	Portable X-ray Services
Dialysis Services	Prescribed Pediatric Extended Care Services (PPEC)
Durable Medical Equipment and Medical Supplies	Private Duty Nursing
Emergency Room Services	Respite Care
Family Planning Services	Rural Health Clinic Services
Federally Qualified Health Center Services	School Based Services (Coordination Only)
Freestanding Dialysis Centers	Therapy Services: Applied Behavioral Analysis (Title 21)
Hearing Services	Therapy Services: Occupational
Home Health Services	Therapy Services: Physical
Hospice/Palliative Care	Therapy Services: Respiratory
Hospital Services – Inpatient	Therapy Services: Speech
Hospital Services – Inpatient > 45 days	Transplant Services
Hospital Services – Outpatient	Transportation Services (medical)
Immunizations	Vision Services

The covered benefits offered by CMS Plan are the same medically necessary benefits provided in the standard Medicaid benefit package, excluding pharmacy and waiver services. The benefit limits and authorized services are described in the Florida Medicaid Provider Handbooks. The University of Florida Board of Trustees (UFBOT), through Ped-I-Care, shall be responsible for arranging for the provision of the benefits listed in Attachment 9 to members assigned to Ped-I-Care.

Care coordination and pharmacy services are the responsibility of the CMS Plan Regional and Area Office staff. Those pharmacy benefits not covered under the contract between the Florida Department of Health and UFBOT include only the drug benefit and not the administration of the drug. All prescribed drugs must be on the CMS Plan formulary.

If specialized products, such as injectable and infusion products are not included in the CMS Plan formulary, arrangements should be made with the CMS Plan Area Office. Only pharmaceuticals approved for use by CMS Plan will be covered.

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

NOTE: Ped-I-Care Title 21 members are not eligible to receive vaccines through the Vaccines for Children (VFC) Program. Routine immunizations are covered by Ped-I-Care. Please bill immunizations and administration using appropriate CPT codes.

Ped-I-Care members are eligible for transportation services. Non-emergent transportation to medical appointments will be provided through Transportation Management Services of Florida (TMS). Please allow for a three day notice when scheduling this service. You may make transportation appointments by calling (855) 739-5986.

Non-emergent ambulance transport will be provided if your child is on a ventilator or otherwise cannot be transported by TMS, but requires prior authorization through MED3OOO. See process for requesting prior authorization (Section 6 – Utilization Management).

6. UTILIZATION MANAGEMENT

Ped-I-Care has designed a utilization management (UM) 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 Ped-I-Care are listed in this manual (Section 5, page 13) 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/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx.

Ped-I-Care's UM program is overseen and directed by a Utilization Management Committee, referred to as the Utilization Management Committee (UMC). The Chair of the UMC is Ped-I-Care's Medical Director. Other members include credentialed physician providers representing primary care, specialty care, and CMS Plan. It is also staffed by Ped-I-Care and MED3OOO staff.

Referrals

PCPs refer to in-network specialty providers for services needed by the child; specialists may also make referrals to other specialists. It is not necessary to obtain a referral number from the third-party administrator; however many specialists do require a referral or consultation request from the requesting provider.

Referrals to Out-of-Network Providers:

Although referrals are made to in-network providers, if the required services are not available within the network, a referral can be made to a non-participating provider. In this case, a Patient Specific Letter of Agreement (PLSOAs) must be completed prior to the authorization being released and services provided to the member. Out of Network providers must agree to Medicaid rates as payment in full.

Authorizations are not needed for Emergency Room visits. However, PSLOAs are needed for Inpatient admits through the ER room (or by any means), if it involves an on-if-network provider. If you have any questions, please call the Ped-I-Care Contracting Team.

Authorization Procedures

Authorization Requests are submitted directly to MED3OOO by the PCPs or other requesting providers. Licensed nurses at MED3OOO review all requests for authorizations and compare them to predefined criteria. Nurses at MED3OOO have the authority to approve all requests that meet the predefined criteria. Requests which are made through this preauthorization process are reviewed for medical necessity in accordance with the guidelines found in the Florida Medicaid Handbooks, Florida Medicaid benefit package, InterQual® decision support criteria, and the health plan's approved medical coverage guidelines.

1) Requests for authorization of services should be submitted to MED3OOO via eINFOsource, visit https://cms.eINFOsource.MED3000.com; fax to (866) 256-2015 using the Referral/Authorization and Notification Form; or a toll-free phone call to (800) 492-9634. If the request meets all relevant criteria, it will be assigned an authorization number by MED3OOO. A request for

continuation of service must be submitted and/or signed by the provider before continuation of service will be pre-authorized for payment.

a. The request must include relevant clinical documentation from the medical record. Requests for services that lack sufficient information to make a determination may be denied or reduced if the supporting clinical information is not supplied.
b. If the request meets STAT criteria due to the member's condition, the provider should call (800) 492-9634 and ask for the UM Nurse to discuss the situation and provide supporting documentation by fax to the MED3OOO UM Nurse. If a request does not meet STAT criteria, it will be processed as a standard, non-urgent request. To be considered a STAT request, there must be a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could result in any of the following:
    (i) Serious jeopardy to the health of a patient, including a pregnant woman or fetus;
    (ii) Serious impairment to bodily functions; or
    (iii) Serious dysfunction of any bodily organ or part.

2) If relevant criteria are not met, the requested service exceeds the allowable Medicaid coverage, is not a covered benefit, or the request requires a prior authorization, then the request will be forwarded to the Ped-I-Care Medical Director or Associate Medical Director ("Medical Director") for review. Only the Ped-I-Care Medical Director is able to deny or reduce a request for authorization of services. The Ped-I-Care Medical Director reviews all potential UM denials and reductions. Only credentialed and designated Ped-I-Care physicians will make a denial or reduction determination. Data consistently shows low denial rates as compared to other health plans in general. Medical Directors also use the guidance of qualified specialists as consultants when conducting medical reviews, as needed.

If the provider has requested authorization for payment of a service that is denied or reduced by Ped-I-Care's Medical Director, a letter will be sent to the provider, the member, and the CMS Plan NCC, explaining the reason for the denial or reduction. The letter will be signed by the Ped-I-Care Medical Director who made the decision. If the child is not enrolled in Ped-I-Care, MED3OOO will inform the member of their ineligibility status.

NOTE: An active authorization listed on eINFOsource for a member does not guarantee that the member is still enrolled. Always check eligibility before providing services.

Services may be authorized up to 60 days in advance and the time period covered can be up to one year (365 days) from the approximate appointment date for medical and surgical specialties and durable medical equipment (DME) and supplies. Specialty providers will need to request reauthorization of services after the one year time period expires.

Most authorizations for therapies (occupational, respiratory, speech, and physical), home health services, and DME will be approved for six months (180 days). See additional information regarding these services in this section under Requests for Therapy Services.

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

Turnaround times for authorization of requested services are as follows:

1) Requests standard authorizations will be approved, denied, or reduced within 14 calendar days of receipt of the request.
    a. The timeframe can be extended up to 14 calendar days if the member or the provider requests an extension or if Ped-I-Care needs additional information to make a decision and it determines that an extension is in the member's best interest.
2) Decisions regarding STAT requests for authorization of urgently needed services will be made within 72 hours and communicated immediately to the provider by telephone. The call will be followed up with a written response.
    a. The timeframe can be extended by up to 14 calendar days, if the member or the requesting provider requests an extension.
3) Decisions regarding requests for retrospective review (services were already provided or started) are made within 30 calendar days of receipt of the request.

Ped-I-Care

Services & Equipment Requiring Prior Authorization (PA)

Some services require that providers obtain prior authorization before the services are performed; these include:

1. **Applied Behavioral Analysis (ABA Therapy) ***
   T21: Concordia authorizes services.
   T19: Services are authorized by the Local Medicaid Area Office.
2. **Durable Medical Equipment ****
   All items including Insulin Pumps, Custom Wheelchairs, and Scooters
3. **Elective Surgical Procedures ****
   Including cosmetic and Plastic/Reconstructive procedures per Medicaid Physician Fee Schedule
4. **Experimental/Investigational Treatment**
   Those newly developed procedures undergoing systematic investigation to establish their role in treatment or procedures that are not yet scientifically established to provide beneficial results for the condition for which they are used.
5. **Genetic Testing (that is not on Medicaid fee schedule, or if genetic testing is with an out-of-network provider)**
   Include documentation supporting how results will impact care delivery decisions.
   Ped-I-Care Genetic Testing Form:
   https://com-peds-pedicare.sites.medinfo.ufl.edu/files/2014/09/Genetic-Test-Request-Form-June-2015.pdf
6. **Hearing Services **/ Hearing Aids ** / Augmentative or Alternative Communicative Systems/Devices ****
7. **Home Health Care Services ***
   Including Home Health Aides, Nursing Visits, and Infusion Services
8. **Inpatient Admissions -** In and Out of Network
   Including Mental Health and Skilled Nursing Facilities
9. **Mental Health Day Treatment Programs**
   Concordia authorizes services.
10. **MRIs, MRAs, CT scans, PET scans *****
11. **Nutritional Supplements ** / Enteral & Parenteral Nutrition ****
12. **Oral Surgery ****
13. **Orthodontia ****
    Include Medicaid score sheet, and films and/or photos if the score doesn't meet guidelines
14. **Orthotics and Prosthetics ****
15. **Out of Network / Out of State Services**
16. **Prescribed Pediatric Extended Care (PPEC)**
    T21: Ped-I-Care and SFCCN authorize services.
    T19: Services are authorized by eQHealth (1-855-444-3747).
17. **Private Duty Nursing ***
18. **Request that Exceeds Medicaid Limits**
19. **Therapeutic Foster Care, Therapeutic Group Care, and Crisis Intervention**
    Concordia authorizes services.
20. **Therapy Services ***
    Physical, Occupational, Speech, and Respiratory
    This includes Therapy Services for Dually Enrolled Children in Early Steps.
21. **Transplants and Related Care**
    Professional services rendered in the office for participating providers do not require prior authorization.
22. **Vision Services ****
    Contact Lenses & Specialty (non-standard) Glasses

** Submit signed plan of care. Include all parent/guardian work/school schedules, explanation from the parent/guardian's doctor of disability and/or limitations (if applicable), notes of care currently being provided (if applicable), physician orders, and documentation of the level of care needed, # of hours/day, and # of days/week. Please indicate whether another child in the same home is receiving the same services. Failure to provide clinical information can result in a delay or denial of the request.*
*** Services and items that have a by report (BR) or prior authorization (PA) indicator on the Florida Medicaid Fee Schedule. Therapy service providers are required to adhere to requirements outlined in the Florida Medicaid – Therapy Services Coverage and Limitations Handbook.*
**** MRIs and CTs do not require PA if the diagnosis code is listed in Appendix D of the Practitioner Services Coverage and Limitations Handbook. For diagnoses not listed, PA is required.*

Notification Only: Emergency Room Visits and Observation Stays

Emergency room visits and observation stays do not require prior authorization, just notification that the service was rendered. This information is used for coordination of care purposes only.

4/11/2016

Requests for Therapy Services

The request for ongoing therapy services (occupational, respiratory, physical and speech/language therapy) is generally made in two phases, the initial assessment and the treatment plan of care. Normally, a primary care or specialty provider makes the referral for the initial assessment. If approved, the therapist conducts the assessment and develops a proposed treatment plan. Signature of the primary care provider (PCP), ARNP or PA designee, or designated physician specialist indicating that they have reviewed the POC and prescribed the therapy. Services cannot be provided prior to the date of this signature. The plan must be approved by the requesting provider, as indicated by his/her signature on the plan, but the actual prior authorization request may be submitted by either the provider or the therapist.

Therapy service providers are required to adhere to requirements outlined in the Florida Medicaid - Therapy Services Coverage and Limitations Handbook in order to receive reimbursement for services. Signature of the PCP, ARNP or PA designee, or designated physician specialist indicating that they have reviewed the POC and prescribed the therapy is required. Therapy services may be authorized for up to a 180-day period. Re-evaluation is required between 150-180 days.

Emergency Services

Use of the emergency department (ED) should be limited to emergencies and cases in which it is not in the best interest of the child to wait until the next office day to receive care. If a child is treated in the emergency department, authorizations are not required, but a notification is required. Notifications are submitted to MED3OOO via eINFOsource, by calling (800) 492-9634, or fax to (866) 256-2015 using the Title 21 Referral/Authorization and Notification Form included in this section.

Hospitalized Patients

Inpatient stays are monitored closely by the concurrent review nurses from MED3OOO. The CMS Plan Nurse Care Coordinators work with the hospital nurses in discharge planning. Any post-discharge services requiring authorization should be submitted to MED3OOO.

New Members

Patients hospitalized at the time of enrollment into Ped-I-Care, must submit an authorization request for continuation of the in-patient benefits to MED3OOO.

PED-I-CARE MEDICAL AUTHORIZATION REQUEST FORM

Ped~I~Care

Fax requests to (866) 256-2015 • For questions call (800) 492-9634
eINFOsource Provider Portal: https://cms.einfosource.med3000.com
Ped-I-Care website: http://pedicare.pediatrics.med.ufl.edu/

One request per form - Separate approvals must be obtained for the facility and the provider.

Program: ☐ **Title 19 MMA-CMS Plan** ☐ **Title T21**

Request Type: ☐ **Standard** ☐ **STAT*** ☐ **Retro** (service already provided) ☐ **ER or Observation Stay Notification**

**Standard timeframe could seriously jeopardize the member's life, health, or ability to obtain, maintain, or regain maximum function.*

Member: ___________________________ DOB: __________ Member ID#: _________________ Age: _____ Gender: ____

	Requesting Provider	Requested Provider/Facility	PCP (If not already listed)
Provider Name			
Specialty			
Tax ID #			
Contact Name			
Phone #			
Fax #			

Diagnosis Code(s):_________________________________ **CPT/HCPCS Code(s), if applicable:** _________________________________

AUTHORIZATION INFORMATION – Requests require the submission of supporting clinical documentation.

Provider/Facility is: ☐ Participating ☐ Non-Participating (Include address, contact info, NPI #, and for T19 the Medicaid #)

Date of Admit/Service: _________________ ☐ Elective (Includes scheduled) ** ☐ Emergent (in 24 hours)

Requested Dates: __________________ through _______________ **Total:** ___________ ☐ Days ☐ Weeks ☐ Months

Procedure: ____

☐ Inpatient Surgery/Services ☐ Outpatient Surgery/Services ** ☐ Transplantation & Related Care
☐ Experimental/Investigational Treatment ☐ Out-of Network Request for: ____________________________________
☐ Other ____

Items/Supplies **
☐ Augmentative Communication System/Device
☐ DME:____________________________________
☐ Orthotics/Prosthetics:_____________________
Hearing: ☐ Hearing Aids ☐ Cochlear Implant
Nutritional Supplements: (Include forms and order)
☐ Enteral ☐ TPN
Vision: ☐ Contact Lenses ☐ Specialty Glasses

Services/Procedures
☐ Diagnostic Imaging of: _________________________
☐ MRI ☐ MRA ☐ CT Scan ☐ PET Scan
☐ Genetic Testing *** (Include Supplemental Form)
☐ Oral Surgery **
☐ Orthodontia ** (Include Medicaid score sheet and films and/or photos if score doesn't meet guidelines)

Days/Week: _____ **Units/Day:** _____ **Total Units:** _____
Choose one service type and include a signed plan of care.

Home Health Services ☐ Home Health Aide
PDN: ☐ LPN ☐ RN ☐ Home Infusion
Is another child in the home already receiving home health services? ☐ Yes ☐ No

Therapy ☐ Physical ☐ Occupational
☐ Speech ☐ Respiratory

Applied Behavioral Analysis (ABA) Therapy
T21 – Fax to Concordia: (305) 514-5321 or (855)698-7790
Questions: (877) 698-7789 option 2, option 1
T19 - *Request through the Local Medicaid Area Office*

Prescribed Pediatric Extended Care (PPEC)
T21 - # Full Days: _________ # Half Days: _________
T19 - *Request through eQHealth @ 1-855-444-3747*

Transportation (For routine, non-emergent transportation to medical appointments)
T21 - *Call TMS @ 1-855-739-5986 to request services* **T19 -** *Call TMS @ 1-866-411-8920 to request services*

** **For services that have a by report (BR) or prior authorization (PA) indicator on the Medicaid Fee Schedule.**
*** **If not on Medicaid fee schedule, or if genetic testing is with an out-of-network provider.**

This communication may contain information that is legally protected from unauthorized disclosure. If you have received this message in error, you should notify the sender immediately by telephone, delete this message from your computer, and securely destroy this document.

Updated: 4/11/2016

Ped~I~Care

PED-I-CARE GENETIC TEST REQUEST SUPPLEMENTAL INFORMATION

Please complete this form and submit along with the Ped-I-Care Medical Authorization Request Form, and supporting clinical documentation. This information will be reviewed by the Medical Director.

Member: ________________________ **DOB:** ________________ **Age:** _______ **Gender:** ______

Requested Test:

Test description (including documentation):

Specificity of test:

Sensitivity of test:

Laboratory:

Laboratory Phone #:

Address:

Major clinical features:

Previous pertinent lab studies/diagnostic investigations:

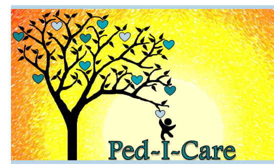
Level of actionable consequences of testing (please answer all that are applicable):

Genetic Counseling for future children in family:

Medical monitoring changes:

Treatment considerations:

Life altering changes:



PED-I-CARE BEHAVIORAL HEALTH AUTHORIZATION FORM

Fax requests to (305) 514-5321 or (855) 698-7790.

For questions call (877) 698-7789, option 2, option 1.

To find forms on our website visit http://pedicare.pediatrics.med.ufl.edu/

Section 1: Member Info and Type of Request

Member: ______________________ **DOB:** __________ **Member ID#:** _______________ **Age:** _____ **Gender:** _____

☐ **Title XIX (19)** ☐ **Title XXI (21)**

☐ **Standard** ☐ **STAT*** ☐ **Retro**

*To be considered a STAT request, there must be a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could result in any of the following: serious jeopardy to the health of a patient, including a pregnant woman or fetus; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

☐ **Initial** ☐ **Continuing**

☐ **Baker Act** ☐ **Voluntary Status**

☐ **Inpatient** ☐ **Residential Treatment** ☐ **Mental Health Day Treatment**

Requested Dates: ____________________ through ____________________ **Total Days Requested:** ___________

Section 2: Providers Involved and Their Contact Info –Please include Member's PCP

	Requesting Provider	Requested Facility	PCP (if not already listed)
Provider Name			
Specialty			
Contact Name			
Phone #			
Fax #			

Provider/Facility is: ☐ Participating ☐ Non-Participating (include contact information above)

Section 3: Clinical Information – Please attach additional pages if more space is needed and any necessary documentation

Diagnosis (include codes):

Procedure (include codes):

This communication may contain information that is legally protected from unauthorized disclosure. If you have received this message in error, you should notify the sender immediately by telephone and destroy this information.

PED-I-CARE BEHAVIORAL HEALTH AUTHORIZATION FORM

Date of Initial Physician Assessment:__________________

Results:

Describe Reason for Admission Being Requested:

Describe Previous Treatments (Inpatient RTC, Outpatient, Other):

Describe Why Less Restrictive Treatment Options are Inadequate to Meet the Clinical Needs of this Member:

This communication may contain information that is legally protected from unauthorized disclosure. If you have received this message in error, you should notify the sender immediately by telephone and destroy this information.

PED-I-CARE BEHAVIORAL HEALTH AUTHORIZATION FORM

Florida HEALTH CMS Managed Care Plan

Current Medications: **Dosage:** **Start Date:**

Previous Medications: **Dosage:** **End Date:**

Special Precautions:

Describe Current Mental Status:

This communication may contain information that is legally protected from unauthorized disclosure. If you have received this message in error, you should notify the sender immediately by telephone and destroy this information.

PED-I-CARE BEHAVIORAL HEALTH AUTHORIZATION FORM

Describe Participation in Treatment:

Describe Current Treatment Plan:

Describe the Need for Ongoing Treatment at this Level of Care:

Discharge Plan:

Estimated Date of Discharge:

Other Information:

This communication may contain information that is legally protected from unauthorized disclosure. If you have received this message in error, you should notify the sender immediately by telephone and destroy this information.

Clinical Review Form (Please use black ink)

Concordia
BEHAVIORAL HEALTH

Medicaid Billing #

NPI #

Form Date (MM/DD/YYYY) / /

Member Medicaid #

Member Date of Birth (MM/DD/YYYY) / /

Member Last Name

Member First Name

Provider Name (Last Name, First Name) or Name of Facility

DCF Contract #

1. Admission Status:

☐ New Client ☐ Existing Client/New Episode
☐ Existing Client – Ongoing Treatment

2. Presenting Problem(s):

3. Current Mental Status Examination: (Please complete all areas)

Orientation:	☐ person	☐ place	☐ time			
Attention:	☐ normal	☐ decreased	☐ hypervigilant	☐ distractible		
Activity Level:	☐ normal	☐ increased	☐ decreased			
Eye Contact:	☐ normal	☐ fair	☐ poor			
Affect:	☐ broad	☐ blunted	☐ flat	☐ inappropriate	☐ labile	☐ restricted
Mood:	☐ euthymic	☐ dysphoric	☐ elevated	☐ expansive	☐ irritable	
Thought Process:	☐ logical	☐ tangential	☐ circumstantial	☐ obsessional	☐ productive	
	☐ impoverished					
Delusions:	☐ absent	☐ paranoid	☐ grandiose	☐ religious	☐ other: ________	
Suicidal Ideas:	☐ absent	☐ past Hx	☐ present	☐ intent	☐ plan	
Homicidal Ideas:	☐ absent	☐ past Hx	☐ present	☐ intent	☐ plan	
Judgement:	☐ intact	☐ fair	☐ poor			
Insight:	☐ intact	☐ fair	☐ poor			
Alcohol/Drug History:	☐ alcohol abuse	☐ smoking	☐ drug abuse: ____________			

4. Current Diagnosis: (*DSM IV Code*) MUST INCLUDE NUMERIC CODE

Axis I: ☐☐☐.☐☐ Description:

Axis I: ☐☐☐.☐☐ Description:

Axis II: ☐☐☐.☐☐ Description:

Axis III: ☐ endocrine ☐ blood ☐ lungs ☐ metabolic ☐ cancer ☐ neurologic ☐ heart
☐ unknown ☐ none ☐ no allergies ☐ allergies: ____________________

Axis IV: ☐ primary support group ☐ occupational ☐ access to health care ☐ educational
☐ social environment ☐ housing ☐ legal ☐ economic ☐ other: ____________

Current *GAF* Score: ☐☐ Highest *GAF* during past year: ☐☐

DIRECTIONS: Complete this *Clinical Review Form*-

r092508v3

PREAUTHORIZATION IS REQUIRED FOR REIMBURSEMENT
Fax to Concordia Behavioral Health at (305) 514-5321

Concordia
BEHAVIORAL HEALTH

Member Medicaid # | Member Date of Birth (MM/DD/YYYY)

Member Last Name | Member First Name

Form Date (MM/DD/YYYY)

Number of past psychiatric admissions: ☐ NA ☐ Unknown

Age of first inpatient admission: ☐ NA ☐ Unknown

Date of most recent inpatient admission: (MM/DD/YYYY) ☐ NA ☐ Unknown

(In Objective & Measurable Terms)

6. Treatment Problem(s) or Symptoms:	**Initial Treatment Goals:**	**Projected completion date**
1.		
2.		
3.		

7. Current Medications: (List medication with dosage)

Medication:	Dosage:	Medication:	Dosage:
1.		4.	
2.		5.	
3.		6.	

8. Medical Care

a. Does this client have a chronic or serious medical condition? ☐ Yes ☐ No

If Yes, is this client receiving medical treatment for this condition? ☐ Yes ☐ No ☐ NA

If client is not receiving medical treatment for this condition explain:

b. Does this client have a primary care provider (PCP) ☐ Yes ☐ No

c. Date of last visit to PCP: (MM/DD/YYYY)

d. Where does this client receive primary care services?

☐ Private MD office Name of PCP:

☐ Community Clinic ☐ Only uses emergency services

☐ NA, Client has no primary care provider / Not receiving treatment

9. Did the client sign a release to contact the primary care provider (PCP)?

☐ Yes ☐ No

If No, Explain: ______

10. Coordination with PCP: Was the client's PCP contacted?

☐ Yes ☐ No

If No, explain: ______

Concordia
BEHAVIORAL HEALTH

Member Medicaid # ________ Member Date of Birth (MM/DD/YYYY) ___/___/_____

Member Last Name ________ Member First Name ________

Form Date (MM/DD/YYYY) ___/___/_____

11. Treatment Modality, Frequency and Duration (6 Month's Worth Maximum)

Service Code	Description	Unit	Frequency: Units per Month	Duration: # of Months
☐ H2019 HO	Therapeutic Behavioral Onsite (TBOS)	15 min	______	______
☐ H2019 HR	Individual / Family Therapy -	15 min	______	______
☐ H2019 HQ	Group Therapy	15 min	______	______
☐ H2012	Behavioral Health Day Service MH	1 hr	______	______
☐ H2012 HF	Behavioral Health Day Service SA	1 hr	______	______
☐ H2017	Psychosocial Rehabilitation Services	15 min	______	______
☐ T1017 HA	TCM - Child	15 min	______	______
☐ T1017	TCM - Adult	15 min	______	______
☐ T1017 HK	Intensive Case Management Team Services	15 min	______	______
☐ H2000 HP	Psychiatric evaluation by Psychiatrist	1 Eval	______	______
☐ H2000 HO	Psychiatric evaluation by ARNP or PA	1 Eval	______	______
☐ T1015	Medication Management	1 Event	______	______
☐ H0031 HA	CBHA	15 min	______	______
☐ S5145	STFC Level 1	1 day	______	______
☐ S5145 HE	STFC Level 2	1 day	______	______
☐ S5145 HK	STFC Crisis intervention	1 day	______	______
☐ H2020 HA	Behavioral Health Overlay Services(BHOS)	1 day	______	______
☐ H0019	STGC	1 day	______	______
☐ INPA	SIPP	1 day	______	______

☐ The Recipient meets eligibility criteria for services

☐ Multidiscilinary team has determined the child is in need of the service (Attach copy of MDT recommendations)

☐ Assessment is court ordered?

☐ Current involvement with ☐ DCF ☐ Foster Care ☐ Protective Services ☐ DJJ

12. Referral to Healthy Behaviors Program

☐ Alcohol/Substance Abuse

☐ Smoking Cessation

☐ Weight Management

Therapy Services Authorization Request Checklist
Title XIX and Title XXI

Therapy service providers are required to adhere to requirements outlined in the *Florida Medicaid - Therapy Services Coverage and Limitations Handbook* in order to receive reimbursement for services. All required documentation to support the request must be submitted at the time of the request. Failure to provide all necessary clinical information can result in a delay or denial of your request. This form may be used as a checklist of submission guidelines and submitted with the Authorization Request Form for therapy services. Therapy services may be authorized for up to a 180 day period.

Initial Requests:

Evaluation and/or Plan of Care (POC) should include the following:

- ☐ Chronological age and functional age;
- ☐ Summary of recipients current health status, including diagnosis(es);
- ☐ Current school grade; document if therapy is being provided by school system;
- ☐ Indicate all therapies member is currently receiving (PT, OT, ST/SLP, ABA/BSA). For multiple therapy group practices, if multiple therapies are utilized (i.e. PT, OT, and/or ST), include an integrated therapy plan. If integration is not feasible, include documentation of why;
- ☐ Modalities;
- ☐ Goals (short term and long term);
- ☐ Frequency/duration of visits; certification period, and total units requested;
- ☐ Signature of the therapist; AND
- ☐ **Signature of the primary care provider (PCP), ARNP or PA designee, or designated physician specialist indicating that they have reviewed the POC and prescribed the therapy. Services cannot be provided prior to the date of this signature.**

Re-Certification Requests (Re-evaluation is required between 150-180 days):

Evaluation and/or Plan of Care (POC) should include the following:

- ☐ Requirements of initial request mentioned above;
- ☐ Compliance with therapies and rehab potential;
- ☐ Family involvement/participation in home therapy program;
- ☐ Percentages of progress toward goals and milestones accomplished since last evaluation, and modifications to the POC;
- ☐ Justification of medical necessity for services to maintain functionality;
- ☐ Frequency/duration of visits, certification period, and total units requested;
- ☐ **Before expiration of the authorization period, the therapist must review and revise the POC and submit it to the PCP for review; AND**
- ☐ **The PCP shall review the recipient's POC and sign to prescribe the continuation of services. Services cannot not be provided prior to the date of this signature.**

1699 SW 16th Ave., 3rd Floor, Gainesville, Florida 32608
Phone: (866) 376-2456 · Fax: (352) 294-8084 · http://pedicare.pediatrics.med.ufl.edu

WORK SCHEDULE FOR PARENT OR LEGAL GUARDIAN

This form must be completed by a supervisor at the current place of employment.
Submit one form for each care giver. Do not send in false information.
Ped-I-Care will notify Medicaid if the information sent in is suspicious.

Employee's Name: ____

Employee's Position Title: ____

Name of Company: ____

Name of Employer: ____

Address (Place of Employment): ____

____

WORK SCHEDULE: (Include work hours for each day scheduled to work)

Day of Week	Total Time Working Including Travel To and From Work	Scheduled Start Time	Scheduled Quitting Time	Variable Work Schedule (hours per day)
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Is the employee scheduled to work holidays? ____

Does the employee work a seasonal or year round schedule? ____

Is the employee the only care giver for the child? ____

Name of Supervisor (Printed): ____

Supervisor's Title: ____

Telephone #s: Company: ____________________ Supervisor: ____________________

Supervisor's Signature: ____________________ Date: ____________________

Member's Name: ____________________ ID #: ____________________

Ped~I~Care

1699 SW 16th Ave., Bldg. A, Gainesville, Florida 32608
Phone: (866) 376-2456 · Fax: (352) 294-8084 · http://pedicare.pediatrics.med.ufl.edu

SCHOOL SCHEDULE FOR PARENT OR LEGAL GUARDIAN

This form must be completed by a school registrar or student advisor at the school where the child's parent or legal guardian is currently enrolled. Submit a form for each care giver.
Do not send in false information. Ped-I-Care will notify Medicaid if the information sent in is suspicious.

Name of Student: ____

Name of School: ____

Address of School: ____

____

SCHOOL SCHEDULE: (Include hours for each day scheduled to attend class)

Day of Week	Total Time at School Including Travel To and From School	Scheduled Class Start Time	Scheduled Class End Time	Additional Hours: Tutoring, Clinical, Lab, etc. (hours per day)
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Does the school close for all Federal holidays? ______________________________

How long is each semester (4 weeks, 8 weeks, etc.)? ______________________________

Does the student attend classes over the summer (June/July/August)? ____________________

Is the student the only care giver for the child? ______________________________

Name of Student Advisor (Printed): ______________________________

Telephone #s School: ____________________ Advisor: ____________________

Advisor's Signature: ______________________________ Date: ____________________

Please include a copy of the student's class schedule and the school's yearly schedule including semester breaks and closing dates for holidays.

Member's Name: ______________________________ ID #: ____________________

Utilization Management (Authorization Decision) Appeals

Ped-I-Care Appeal Process

Ped-I-Care has a formal appeals process with specific procedures and time frames established in accordance with Ped-I-Care's contractual requirements. An appeal of Ped-I-Care's decision to deny or reduce a service can be requested by the member, parent, provider, or anyone who has been authorized (in writing) by the member or legal guardian. Any additional information for consideration should be submitted with the appeal request. The appeal will be reviewed by Ped-I-Care and the appeal decision will not be made by any individual who rendered the initial decision.

When to Make the Appeal

An appeal must be made within 90 days from the date the initial denial or reduction decision is received. Appeal requests should NOT be sent to MED3OOO.

There are 3 ways to make an appeal to Ped-I-Care:

1) Call us at one of the following numbers and ask for the Ped-I-Care Medical Review Coordinator: Telephone (352) 627-9100 or (866) 376-2456
    - If the appeal is made by phone, then an appeal request must be sent in writing within 10 days of the telephone request.
2) Send a written appeal to:
   Ped-I-Care Medical Review Coordinator
   1699 SW 16th Avenue
   Gainesville, FL 32608-1153
3) Fax Ped-I-Care a written appeal to: (352) 955-6518

An appeal request form is available on Ped-I-Care's website: http://pedicare.pediatrics.med.ufl.edu/ and is contained in this Provider Manual.

Ped-I-Care's Response Time

The member, provider, and NCC will be notified of Ped-I-Care's appeal decision 45 days of receipt of the appeal request, unless it is an expedited appeal. The appeal time frame may be extended up to 14 calendar days, if the member or provider requests an extension.

Expedited Appeals

If an expedited appeal is requested and it meets the STAT criteria, then Ped-I-Care will complete its review and will communicate its decision within 72 hours of the time the request is received. The timeframe can be extended by up to 14 calendar days, if the member or provider requests an extension. If a request does not meet STAT criteria, it will be processed as a standard, non-urgent request. To be considered a STAT request, there must be a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, that the absence of immediate medical attention could result in any of the following:

1) Serious jeopardy to the health of a patient, including a pregnant woman or fetus.
2) Serious impairment to bodily functions.
3) Serious dysfunction of any bodily organ or part.

Continue Previously Authorized Services during an Appeal

We may continue previously authorized services when an appeal is requested. For Ped-I-Care to continue these services, a written request must be made to Ped-I-Care's UM Department by whichever of the following time periods is later:

1) Within 10 business days from the date of the Notice of Denial Letter; or
2) Within 10 business days after the date your current services will end or be limited.

Ped-I-Care will inform the member that if the member does not win the appeal then the member may have to pay for the cost of the services.

If a member or provider disagrees with Ped-I-Care's decision, then the member or provider may appeal to the CMS Plan Statewide Network Grievance Panel. If a member or provider wishes to appeal to the CMS Plan Statewide Network Grievance Panel, please call the Ped-I-Care UM Department for details on submitting this type of appeal.

Tracking Appeals

Ped-I-Care tracks all appeals and the quantity and outcomes of the appeals are reported to CMS Plan on a quarterly basis.

MED3OOO Utilization Management Department
Referral and Authorization
Phone: (850) 478-6060 or (800) 492-9634
Fax: (850) 471-2240 or (866) 256-2015

Ped-I-Care Utilization Management Department
Carissa Mitchell, UM Manager
Phone: (352) 627-9130 or (866) 376-2456
Fax: (352) 294-8085

PED-I-CARE AUTHORIàATION DENIAL APPEAL REQUEST FORM

You can fax this form to us at (352) 294-8084 OR mail this form to us at: Ped-I-Care, Attn: Medical Review Coordinator, 1699 S.W. 16th Ave., Bldg. A, Gainesville, FL 32608. You can call us to make an appeal at (866) 376-2456. If you appeal by phone, you must then send an appeal to us in writing within 10 days of your telephone request. If you have questions, please feel free to call us at (866) 376-2456, and ask for our Utilization Management Department; or visit our website at http://pedicare.pediatrics.med.ufl.edu/. A written decision will be sent to the member, provider(s), and CMS Area Office.

PLEASE DO NOT SEND THIS APPEAL OR ANY MEDICAL INFORMATION BY EMAIL!

Appeal Type: ☐ **Standard** ☐ **Fast** (Use only when your doctor thinks it is medically necessary)

☐ **Title XIX (19)** ☐ **Title XXI (21)**

Member: ____________________________**DOB:**_______________**Member ID#:**______________________

Name of person requesting appeal: ____

Relationship to member: ☐ **Parent/Guardian** ☐ **PCP** ☐ **Other:**___________________________

Name of provider who ordered the service:____

Service appealed:____

Service appealed was: ☐ **Denied** ☐ **Reduced/Limited** (Please attach a copy of the Notice of Denial letter that you received)

Check if new information is attached: ☐ **Notes** ☐ **Tests/Studies** ☐ **Photos** ☐ **Imaging** ☐ **Other:** __________

Please use this area to explain why this request should be approved. You may use additional paper, if needed.

We may continue your previously authorized services when you file an appeal. For us to continue your services, you must let us know in writing whether you to continue your services by whichever of the following time period is later, either: 1) within 10 business days from the date of this notice; or 2) within 10 business days after the date your current services will end or be limited. Please mark the box to tell us if you would like to continue previously authorized services: ☐ NO ☐ YES (If you mark "yes" and do not win the appeal, you may have to pay for the cost of the services)

This communication may contain information that is legally protected from unauthorized disclosure. If you have received this message in error, you should notify the sender immediately by telephone and discard this message.

CMS/Ped-I-Care Medical Review Process

Requesting a Referral or Authorization - The PCP/Specialist enters the referral request in eINFOsource, the CMS NCC enters the referral request in Facets, or the PCP/Specialist or NCC faxes the referral or authorization request to MED3OOO at **(866) 256-2015**. Call MED3OOO at (800) 492-9634 if you have questions.

Title 21 timeframes are: Routine - 14 days, STAT* - 72 hours, Retro - 30 days
* If STAT criterion is not met, it is processed as a Routine request.

MED3OOO reviews and tracks each request in Facets.

1. If the request and information submitted meets medical necessity based on the Medicaid Handbook or Interqual Criteria, MED3OOO assigns an authorization number and the request is approved.
2. If it does not meet criteria, is an out-of-network request, or is a mandatory medical review service (such as therapy), MED3OOO sends the review to Ped-I-Care for the Medical Director to make a decision to approve, deny, or reduce the request.
3. If more information is needed, MED3OOO requests the information from the person that submitted the request or the ordering provider. If needed, Ped-I-Care sends a letter of **time extension** to the member, provider, and NCC. Once the information is received (or nothing new is submitted), MED3OOO follows the steps in numbers 1 and 2 above.

The request is **Approved**. MED3OOO assigns an authorization number and notifies the requesting provider. The CMS NCC can locate the approval in Facets.

The request is sent for CMS/Ped-I-Care Medical Director Review. The MD decides to:

1. Approve, deny, or reduce the request. Ped-I-Care notifies MED3OOO of the decision;
2. Send the request to a consultant for recommendations. Ped-I-Care sends the request to the consultant and the response is sent to the Medical Director for a final decision; or
3. Request more information. (Ped-I-Care sends the request for to MED3OOO to obtain from the requesting or submitting provider. Once the information is obtained [or nothing new is submitted], the Medical Director is notified and step 1 or 2 above is followed.)

In addition to records supporting medical necessity, requests should include:

MRI – Prior film reports and documentation consistent with medical necessity

Orthodontic – The Medicaid score sheet and films and/or photographs if the score doesn't meet Medicaid guidelines

Out-of-Network/Non-Par Providers and Facilities – Detailed contact information for the provider and facility, why a participating provider is not being requested, and separate request submissions for the provider and facility

HHA/PCS – All parent/caregiver's work/school schedules, explanation from parent/caregiver's doctor of disability and/or limitations (if applicable), documentation of level of care needed, hours/day, and days/week

PDN/PPEC – Documentation of care the parent/caregiver is willing/able to provide, level of care needed, signed plan of care, and requested hours/day and days/week

PT/OT/ST – Evaluation, signed plan of care, documentation, units or minutes/day (session), days/week, and all therapies currently receiving

Residential Treatment – Documentation of failed attempts of less restrictive treatments and therapies

The request is **Denied or Reduced.** Ped-I-Care sends a decision letter to the member, provider, and CMS NCC with the denial/reduction reason and steps to appeal the decision. MED3OOO enters the decision into Facets.

Only a Medical Director can deny or reduce a request.

Ped-I-Care Medical Review Appeal Process

Note: If STAT criteria are not met, the appeal is processed as a routine request.

Following Medical Review by a Ped-I-Care Medical Director, a denial or reduction decision is made for the requested service, item, provider, or facility. Ped-I-Care sends a letter to the member/parent, CMS Plan Care Coordinator (CC), Primary Care Provider (PCP), and the requesting provider. If an appeal is not pursued, the decision does not change.

***Request to Continue Services**

The member/parent may request that the services continue until the appeals process is completed. The member/parent may be responsible for the cost of the services if the decision is upheld. For both Titles 19 and 21, a written request to continue services must be sent within 10 days.

Appeal*

The member, parent, provider, or CC can ask for appeal by telephone or in writing. An appeal must be filed within 30 days of receiving the decision letter. An appeal can be filed orally or in writing; it must also be submitted in writing within 10 days of the oral request.

Additional information supporting the request and an appeal request should be faxed to Attn: Medical Review Appeals Coordinator at (352) 294-8084. Appeals should not be faxed to MED3OOO. For Title 19, an appeal acknowledgement letter is sent by Ped-I-Care within 5 business days if the request is not for a STAT appeal. If you have questions about an appeal, call (866) 376-2456 or (352) 627-9100.

Title 19

Ped-I-Care Appeal: The request is reviewed by the Ped-I-Care Appeal Committee (see description on right). The appeal decision is due within 45 days (STAT 72 hours). Both decision timeframes can be extended 14 calendar days. Ped-I-Care sends a letter with the decision to the member/parent, CMS Plan CC, PCP, and the requesting provider.
Note: For Title 19, there is only 1 level of Ped-I-Care appeal.

If member or parent does not want to file an appeal with Ped-I-Care or does not agree with Ped-I-Care's appeal decision, they have 90 days to file a **Medicaid Fair Hearing <u>or</u>** 1 year to file with the **Subscriber Assistance Program** (SAP). The SAP will not consider an appeal that has been to a Medicaid Fair Hearing.

Title 21

Ped-I-Care 1st Level Appeal: The request is reviewed by the Ped-I-Care Appeal Committee. The Appeal Committee consists of a Ped-I-Care Medical Director who was not involved in the initial decision, Ped-I-Care Asst. Director for Utilization Management, and Ped-I-Care Asst. Director for Compliance and Quality Improvement. Other parties to the Appeal Committee may include the Ped-I-Care Executive Director, UM Manager, UM staff member, CC, and a physician who specializes in the condition being considered. The appeal decision is due within 45 days (STAT 72 hours). Both decision timeframes can be extended 14 calendar days. Ped-I-Care sends a letter with the decision to the member/parent, CMS Plan CC, PCP, and the requesting provider.

If the member or parent does not agree with the decision of Ped-I-Care's Appeals Committee, they have 90 days to file an appeal with the **CMS Plan Statewide Grievance Panel**.

7/27/2015

7. BILLING AND CLAIMS PAYMENT

Ped-I-Care claims are paid by the third-party administrator, MED3OOO. Ped-I-Care pays for services at the prevailing Medicaid rate and will follow Medicaid guidelines for service limits. Payments are made according to the Utilization Management policies described in this manual and shall be made in accordance with applicable state and regulatory guidelines.

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

Physician extenders (ARNPs and Physician Assistants) may bill "incident to" an enrolled provider in accordance with Medicaid guidelines. 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. The physician must be on-site or readily available by phone during the visit/service provided and must sign the chart. Physician extenders may see patients and bill in their own names but will be reimbursed at a reduced rate.

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

- Member must have been enrolled in the month service was delivered
- Service is a covered and/or an authorized benefit
- Provider must be enrolled in the Ped-I-Care network (unless out-of-network services are authorized)
- Uses HIPAA and Florida law compliant format for claims submission
- Claim must be complete and accurate
- Claims for specialty services and procedures need to include the referral/authorization number
- Procedure must be consistent with the diagnosis code listed on the claim
- Claims must be submitted within 365 days of the date of service

Electronic Claims Submission

Electronic claims are the preferred method of claims submission.

To submit claims electronically contact Change Healthcare at (877) 363-3666.
(MED3OOO/Ped-I-Care's Title 21 Electronic Payer I.D. is EM205.)

To submit claims electronically through Availity please access the following website:
www.availity.com

The Payer I.D. for Ped-I-Care Title 21 is M3FL0014.

Electronic Remittance advice (also known as the standard data transaction set 835) has been implemented. Please go to http://changehealthcare.com or call Change Healthcare at (866) 506-2830 to

learn more. If you have not signed up for Electronic Funds Transfer please consider doing that at the same time.
MED3OOO adheres to all Electronic Data Interface Standards inclusive of 5010 standards. Please contact your clearinghouse for additional information.

As a part of compliance with Industry Standards MED3OOO will institute all edits and audits associated with ICD-10 when implemented. Please make sure your practice is prepared to make this change.

Paper Claims

Send paper claims to:

MED3OOO/Ped-I-Care Title 21
PO Box 981733
El Paso, Texas 79998-1733

Ped-I-Care providers must accept the payment made by CMS Plan through Ped-I-Care's fiscal agent (MED3OOO) as payment in full and may not request payment or balance bill Ped-I-Care enrollees or family members. If your claim cannot be paid as submitted, MED3OOO will give the denial 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, within 40 days if submitted on paper and within 20 days if submitted electronically.

If you have questions about the payment or the EOB, please contact MED3OOO 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.

MED3OOO offers eINFOsource, 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.

The internet address is: https://cms.eINFOsource.MED3000.com. For more information or to establish a login for your office, please contact the MED3OOO Customer Service at (800) 664-0146.

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

8. CLAIMS APPEALS

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 MED3OOO. Each claim submitted is noted as paid or denied and 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 MED3OOO Customer Service at (800) 664-0146. MED3OOO 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 60 calendar days from the date of the EOB using the form included in this section.

The appeal request must consist of:

- The completed appeal form
- Documentation supporting the request
- Copy of the original claim

The appeal should be mailed to:

University of Florida ICS/Ped-I-Care
1699 SW 16th Avenue
Gainesville, FL 32608
Attn: Claims Appeals

Fax: (352) 294-8092

The appeal will be reviewed and researched by Ped-I-Care staff and forwarded to the Manager of Claims Services for final determination. If payment is denied by MED3OOO, the provider will receive a written response within 45 days of MED3OOO'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 MED3OOO 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 15 days of the receipt of the denial of the first appeal. The second-level appeal shall be mailed to MED3OOO at the above Claims Appeals address.

These go through the UM process at MED3OOO and then get forwarded to the Ped-I-Care Medical Director for review.

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

University of Florida Integrated Care System (CMS/Ped-I-Care)
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

☐ 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
1699 SW 16th Avenue, Third Floor
Gainesville, FL 32608
Fax – 352-294-8092

9. MEMBER RIGHTS, RESPONSIBILITIES AND COMPLAINTS

Member Rights

Each member/family has a right to:

- Be treated with respect, courtesy, and with recognition of their dignity
- Protection of their privacy
- A prompt, courteous and responsible response to their questions and requests
- Information about diagnosis, treatment options, and prognosis
- 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
- Participate in decisions regarding health care provided to themselves/their child
- Receive information about Ped-I-Care and its services and policies
- Express complaints or grievances regarding the program or care provided

Member Responsibilities

Members and/or family members are responsible for:

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

Member Complaint and Grievance Procedures

Participants enrolled in 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 Ped-I-Care toll-free at (866) 376-2456 (ask for Member Services) or locally at (352) 627-9100. If a participant complains to the CMS Plan Nurse Care Coordinator the complaint will be passed on to the Member Services Office of Ped-I-Care. If the family complains to the provider about the services received through the 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.

10. GRIEVANCES

Providers and members may file a grievance on any serious issue or when the usual protocols have been exhausted and the provider is still dissatisfied. To file a grievance, call the Ped-I-Care Office and ask for the Grievance Coordinator. This staff member 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. The Ped-I-Care Medical Director will convene the Provider Grievance Committee within 15 business days of receiving the written grievance. The Committee will consist of the Ped-I-Care Medical Director, Ped-I-Care 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 10 business days following the meeting. Note that the member has the right to request the continuation of benefits while utilizing the grievance system.

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

The Grievance Committee can be contacted in writing at:

Grievance Coordinator - Ped-I-Care
1699 SW 16th Ave.
Gainesville, FL 32608

Other Issues and Concerns

Concerns about Ped-I-Care members may be directed to the member's CMS Plan Nurse Care Coordinator (NCC) (See Section I – Contact Information) or to the Ped-I-Care Member Services Office at (866) 376-2456 or (352) 627-9100. Other issues and concerns should be directed to Ped-I-Care staff at these same numbers. This process will be informal and handled verbally, unless otherwise requested by the provider.

Providers may call 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 Ped-I-Care Executive Director and to the Quality and Utilization Management Committee (QUMC) at the bi-annual meeting. These will be reviewed and any trends noted for possible improvements in the system or services rendered by Ped-I-Care or its subcontracted TPA, MED3OOO.

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

Network/Provider Relations Manager - Ped-I-Care
1699 SW 16th Ave.
Gainesville, FL 32608

PEDIATRIC INTEGRATED CARE SYSTEM
PROVIDER GRIEVANCE FORM

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

Ped-I-Care
Attn: Grievance Coordinator
1699 SW 16th Ave., Third Floor
Gainesville, FL 32608

Phone: (352) 627-9100
Toll-Free: (866) 376-2456
Fax: (352) 294-8092

Date of Grievance: _____/_____/_________ ***(please enter today's date)***

Name: ____ ***(please include MD, DO, 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 a result of this grievance procedure:

____
____
____

11. 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 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, 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 Ped-I-Care Network. These include CMS Plan approval 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.

Ped-I-Care will evaluate the following quality indicators:

- 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
- Mortality
- Health status indicators:
    - Immunization (percent of members at age 2 years who have completed the basic immunization series)
    - Child Health Check-Up 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)
    - Other health care services utilization
- Family requests for reassignment of Primary Care Physicians
- Member or family perspectives of care, including complaints and grievances
- Percent of members or families who report positive perceptions of care
- Provider satisfaction including turn-over rates, physician disenrollment, and satisfaction with payment and authorization systems
- Compliance with medical record documentation requirements (outlined in Section 11)

Outcome indicators and sources of information used to measure them have been identified. Data from claims, as well as patient and provider satisfaction surveys also will be reviewed. In addition to this data driven approach to quality, 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.

A Ped-I-Care Quality Improvement Nurse reviews medical records of network providers at least once

every three years. The chart reviews are completed using a tool developed from the guidelines for medical records in the Provider Manual. 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. The site visit survey tool is available to providers for review. If you would like a copy of the site survey tool please call Ped-I-Care's Quality Improvement Department at (866) 376-2456 or (627-9100). Providers will receive feedback summarizing the review findings.

12. MEDICAL RECORD REQUIREMENTS

Ped-I-Care Quality Improvement Nurses use a number of record review tools based on the following criteria:

1. General Medical Record Requirements
    a. Ped-I-Care conducts medical record review of members to ensure that practitioners provide quality health care that is documented according to established standards and confidentiality guidelines.
    b. Providers maintain and safeguard the confidentiality of information obtained in accordance with the privacy and confidentiality requirements of federal and state law, including specifically 42 CFR, Part 431, Subpart F, regarding confidentiality and disclosure of information.
    c. Confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease in accordance with section 384.30(2), F.S. is maintained.
    d. Providers maintain compliance with the Privacy and Security provisions of the Health Insurance Portability and Accountability Act (HIPAA).
    e. The audit tools that are used to conduct the site and chart reviews are available to providers for review. If you would like a copy of these audit tools please call Ped-I-Care's Quality Improvement Department at (866) 376-2456 or (352) 627-9100.
    f. At least every 3 years random audits of medical records are conducted by Ped-I-Care's Quality Improvement Department to evaluate adherence to the medical records requirements. Practice sites include both individual offices and large group facilities.
    g. Medical records are maintained in a fashion that conforms to good professional medical practice and permits effective professional medical review and audit.
    h. Medical records include the quality, quantity, appropriateness, and timeliness of services performed.
    i. Ped-I-Care network providers are the custodians of the medical records.
    j. Ped-I-Care network providers retain medical records for a minimum of 7 years from the date of last entry (or treatment) or as otherwise required by the appropriate State of Florida Department of Health records retention schedules.
    k. Upon request, Ped-I-Care network providers provide Ped-I-Care and/or the Florida Department of Health prompt access to all member medical records.
    l. Members have access to their medical records in accordance with Federal & State laws.
    m. If a member changes Ped-I-Care network providers, the medical record or a copy is forwarded to the newly designated Ped-I-Care network care provider within 10 working days from receipt of the request.
    n. All service providers must maintain a medical record for each member and each member's medical record must meet the following medical record requirements, as appropriate:
        i. Each record must contain identifying information on the member, including name, member identification number, date of birth and sex, and legal guardianship.
        ii. Each record must be legible and maintained in detail.

iii. Each record must contain a summary of significant surgical significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs, and current medications.
iv. All entries in each record are dated and signed.
v. All entries in each record must indicate the chief complaint or purpose of the visit, the objective findings of practitioner, diagnosis or medical impression.
vi. All entries in each record must indicate studies ordered, for example: lab, x-ray, EKG, etc.
vii. All entries in each record must indicate therapies administered and prescribed.
viii. All entries in each record must include the name and profession of the practitioner rendering services, for example: M.D., D.O., or O.D., including signature or initials of the practitioner.
ix. 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.
x. Each PCP record must contain an immunization history.
xi. Each record must contain a record of emergency care and hospital discharge summaries.

2. Additional Requirements for Primary Care Physicians
   In addition to the General Medical Record Requirements, Primary Care Providers must meet the following requirements:
   a. Child health check-ups are scheduled according to AAP guidelines.
   b. Each record contains an immunization history.
   c. Physicals include age appropriate tests: vision, hearing, hemoglobin, lead, urine, etc.
   d. Physicals include age appropriate anticipatory guidance and risk screenings: TB, lead, STDs, etc.
   e. For adolescent females, record has reference to family planning.
3. Additional Requirements for Therapy and Behavioral Health Providers
   In addition to the General Medical Record Requirements, Therapy and Behavioral Health providers must meet the following requirements:
   a. Maintain a medical record for each member. Each member's medical record:
      i. Includes documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of services performed;
      ii. Is legible and maintained in detail consistent with the clinical and professional practice which facilitates effective internal and external peer review, medical audit, and adequate follow-up treatment; and
   b. For each service provided, clear identification as to:
      i. The physician or other service provider;
      ii. Date of service;
      iii. The units of service provided; and
      iv. The type of service provided.
4. Additional Requirements for Hospitals
   In addition to the General Medical Record Requirements, Hospitals must meet the following requirements:
   a. Each record contains a record of the discharge plan.
   b. Each record contains documentation that the member's PCP was notified of the member's hospitalizations, treatments, and medications.

13. PREVENTION OF FRAUD AND ABUSE

CMS Plan requires that we have a compliance program. This program is dedicated to the prevention and detection of fraud and abuse through a collaborative effort. Appropriate enforcement measures based on compliance findings will be undertaken after consultation with or notification of CMS Plan. Provider and member fraud can manifest in multiple ways and we solicit and anticipate the cooperation of diligent providers and members to uncover and report this type of activity. Our goal is to prevent, detect, and correct any violations. Ped-I-Care actively attempts to prevent and identify suspected incidents of fraud and abuse. All activities seen as fraud and/or abuse will be reported to the Ped-I-Care Compliance Department for investigation and follow-up. Providers must comply with all aspects of Ped-I-Care's Compliance Program and its fraud and abuse plan/requirements.

Compliance Activities and Investigations

Ped-I-Care proactively conducts both prospective and retrospective searches and analyses to seek potential fraud and abuse using resources such as (but not limited to) claims, utilization management, quality management, grievance/appeals, complaints, and random chart audits. Pursuant to regulations, in the event of suspected fraud and/or abuse, chart audits may be conducted without prior notice. Findings suggestive of fraud and abuse will be reported to CMS Plan and other agencies as appropriate and needed.

Provider Training

Our Compliance Program trains providers and their staff members and investigates fraud and abuse. Completion of compliance training is mandatory. Providers must take the training when first contracted and annually thereafter. Providers and practices are responsible for ensuring that their staff takes the training when hired and annually. The online training tutorial is available at http://pedicare.peds.ufl.edu/compliance/index.html.

Excluded Provider Notification

Ped-I-Care routinely monitors the Health and Human Services (HHS) Office of the Inspector General's List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM) (which includes the former Excluded Parties List System [EPLS], Medicaid Termination lists, Florida Department of Health (DOH) license notifications, AHCA Final Orders, and other sources to identify individuals excluded from participation in Florida Medicaid. Providers must notify Ped-I-Care immediately if they become ineligible to participate in federally funded programs or receive federal money.

Reporting Fraud and Abuse

Confidentiality will be maintained for the suspect person or entity and the person reporting, and all rights afforded to both providers and members will be reserved and enforced during the investigation process.

You may report suspected cases of fraud and abuse anonymously. You may also report confidentially without fear of retaliation. You may report in one or more of the following ways:

- By calling the **Ped-I-Care Compliance Fraud & Abuse Hotline** toll free at (**866) 787-4557** or locally at (352) 627-9300.
- By faxing information to (352) 294-8080 or
- By mailing it to:

Ped-I-Care Compliance Department
1699 SW 16th Avenue
Gainesville, FL 32608-1153

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free [866] 966-7226 or [850] 414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

Provider Examples

Fraud:

- Billing for an office visit when there was none, or adding additional family members' names to bills
- Billing for services that were not provided, e.g., a chest x-ray that was not taken
- Billing for more time than was actually provided, i.e., counseling, anesthesia, etc.
- Requiring the patient to return to the office for more visits when another appointment is not necessary
- Ordering unnecessary x-rays, blood work, etc.
- Upcoding (billing for a more involved or time-consuming service than was actually provided), e.g., providing a simple office visit and billing for a comprehensive visit
- Billing for transportation that is not medically necessary or is not related to health care
- Billing for services that are not medically necessary, or are not for a medical purpose
- Accepting payment from another provider, including sharing in the reimbursement paid, as a result of referring a patient to the other provider
- Duplicate billing such as billing CMS Plan or Ped-I-Care and another payer and/or the patient/family for the same service
- Having an unlicensed person perform services that only a licensed professional should render, and billing as if the professional provided the service

- Unbundling codes (billing separately for each component of the code) which results in increased payment, when one comprehensive code includes all related services at a lesser reimbursement rate. This also includes incidental procedures that are typically done as part of a larger procedure and, because they take little extra effort, are not usually reimbursed separately. Examples include laboratory blood test panels, surgical procedures, etc.

Abuse:

- Over utilization of health care services
- Billing a Child Health Check-up on the same day as a sick visit
- Provider billing irregularities
- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Improper billing practices
- Inaccurate coding
- Misrepresentation of professional credentials/licensing/status of licensure

Member/Patient/Family Examples

Fraud:

- Intentionally underreporting income, assets, resources etc.
- Loaning an identification card to another person
- Using multiple ID cards and/or numbers
- Forging or altering a prescription or fiscal order
- Intentionally receiving duplicative, excessive, contraindicated or conflicting health care services or supplies
- Re-selling items provided by our program
- Misrepresentation of a medical condition
- Falsifying work or school schedule hours in order to gain services

Abuse:

- Not living where reported in order to gain services
- Residing out-of-state
- Tampering with prescriptions
- Drug seeking behaviors
- Failure to report third party liability

Overpayment

Any amount that is not authorized to be paid whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Examples of Overpayment:

- Payment for provider, supplier, or physician services after benefits have been exhausted, or where the member was not entitled to benefits
- Payment for non-covered items and services, including medically unnecessary services or custodial care furnished to a member
- Payment based on a charge that exceeds the reasonable charge
- Duplicate processing of charges/claims
- Payment to a physician on a non-assigned claim or to a member on an assigned claim. (Payment made to wrong payee.)
- Primary payment for items or services for which another entity is the primary payer
- Payment for items or services rendered during a period of non-eligibility
- Payment for a higher level E&M code than is documented in the medical record

Responsibility

Ignorance of guidelines is not a defense against a fraud or abuse allegation. The standard is KNEW OR SHOULD HAVE KNOWN. The best remedy for fraud and abuse problems is avoiding them and by taking an active role in detection, reporting, prevention, and education. We need your help. Report suspicions to **Ped-I-Care's Fraud & Abuse Hotline** at (**866) 787-4557**.

14. CONTRACT DEFINITIONS

AAP - American Academy of Pediatrics.

Abuse – Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or enrollee/member practices that result in unnecessary cost to the program.

Advance Directive – A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Adverse Determination - A determination by UFBOT, through Ped-I-Care, or its designee that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet UFBOT's, through Ped-I-Care requirements for necessity, appropriateness, health care setting, level of care or effectiveness, level of care or effectiveness, so that requested service or payment of it is therefore denied, reduced or terminated

Appeal – The formal request for review by a member or provider for the reconsideration of a benefit.

Assignment - The process by which CMS Plan enrollees are transferred to and become members of University of Florida College of Medicine, Department of Pediatrics integrated care system known as Ped-I-Care.

Behavioral Health Network - Those organizations with which the Florida Department of Children and Families, through its district Alcohol, Drug Abuse, and Mental Health Offices, contracts for provision of behavioral health services to eligible seriously emotionally disturbed and substance dependent children pursuant to Title 21 of the federal Social Security Act.

Behavioral Health Services – Include mental health and substance abuse services provided to individuals with mental health, substance abuse, and mental health and substance co-occurring disorders for the maximum reduction of the members' disability and restoration to the best possible functional level. Services are limited to those which are medically necessary and are recommended by a treating practitioner. Arranging for member's inpatient and outpatient care, and emergency/crisis support services is the responsibility of UFBOT, through Ped-I-Care.

Benefits - A schedule of health care services to be delivered to members assigned to the Ped-I-Care program.

Business days – Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday, and Friday. State holidays are excluded.

Business hours – 8:00 A.M. to 5:00 P.M. in the time zone of the member or provider, on all business days, except Member Services, which is available 8:00 AM to 7:00 PM for members on business days.

Calendar days – All days, including weekends and holidays.

Care Coordination - A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

Child Health Check-Up – Formerly EPSDT - The Early and Periodic Screening, Diagnosis and Treatment program administered by the Title XIX program, but adhered to for the Title 21 children served through this contract. Child Health Check-Up services are comprehensive and preventive health examinations provided on a periodic basis intended to identify and correct medical conditions in children and young people before the conditions become serious and disabling. Policies and procedures are described in the Medicaid Child Health Check-Up Coverage and Limitations Handbook.

Children and Families, Department of (DCF) – The state agency responsible for overseeing programs involving behavioral health, childcare, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness, and programs that identify and protect abused and neglected children and adults.

Centers for Medicare and Medicaid Services (CMMS) – The agency within the United States Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title 21 of the Social Security Act.

Children with Special Health Care Needs - Children under age 21 years whose serious and 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.)

Children's Medical Services Managed Care Plan (CMS Plan) - A statewide-managed care service system that includes health care providers as defined in Chapter 391, F.S.

Clinic - A facility that is organized and operated independent of any institution to furnish preventive, diagnostic, therapeutic, rehabilitative, or palliative care, goods, or services to outpatients.

Complaint - Any expression of dissatisfaction by a member, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the UFBOT, through Ped-I-Care's contract.

Complainant – A parent, a legal guardian, an authorized representative of the parent or legal guardian or a provider submitting a complaint.

Contractor - The organizational entity serving as the primary contractor and with whom this agreement is executed. The Contractor for this agreement is The University of Florida Board of Trustees ("UFBOT"). UFBOT enters into this agreement for the benefit of the of the UF Pediatric Integrated Care System ("Ped-I-Care"), Department of Pediatrics, College of Medicine, University of Florida.

County Health Departments (CHDs) – Organizations administered by the Department of Health for the purpose of providing health services as defined in Chapter 154, F.S. which includes the promotion of public health, the control and eradication of preventable diseases, and the provision of primary health care for special populations.

Covered Services – The services listed in Attachment 9 of this agreement, which UFBOT, through Ped-I-Care, arranges to be provided to Ped-I-Care members.

DCF – Department of Children and Families.

Department or DOH - The Department of Health.

DHHS - United States Department of Health and Human Services.

Disenrollment - The department-approved discontinuance of enrollment in CMS Plan.

Durable Medical Equipment (DME) - Medical equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose; is generally not useful in the absence of illness or injury; and is appropriate for use in the patient's home.

Emergency Services and 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. If such a condition exists, emergency services and care include the care or treatment necessary to eliminate the emergency medical condition within the service capability of the facility.

Emergency medical condition - As defined in section 641.47, F.S., means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.
d. With respect to a pregnant woman:
    i. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
    ii. That a transfer may pose a threat to the health and safety of the patient or fetus; or that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Enrollee – A child who has been determined eligible for and is receiving health services from CMS Plan.

Enrollment - The process by which an eligible child becomes an enrollee of the CMS Plan.

Facility - Any premises owned, leased, used or operated or maintained by an ICS Network provider who contracted with UFBOT to participate as a provider in the Ped-I-Care Provider Network to provide health care services to members, as required by this Contract.

Family-Centered Care – An informal partnership formed with children with special health care needs and their families, the primary care providers, CMS Plan Nurse Care Coordinators and UFBOT Ped-I-Care 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 Healthy Kids Corporation – The entity established in s.624.91 F.S., responsible for eligibility determination for Title 21 of the Social Security Act, known as the Florida KidCare Program.

Florida KidCare Program - A program authorized by the Florida legislature in ss. 409.810-409.821, F.S., to provide a defined set of health benefits to previously uninsured, low-income children through the establishment of a variety of affordable health benefits coverage options. Those options include:

a. Medicaid;
b. MediKids;
c. Florida Healthy Kids Corporation; and
d. Children's Medical Services Managed Care Plan.

Fiscal Year – The state fiscal year is from July 1 through June 30.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Furnished - Means supplied, given, prescribed, ordered, provided, or directed to be provided in any manner.

Grievance – A written complaint submitted by or on behalf of a member or a provider to UFBOT, through Ped-I-Care, or the Department regarding the availability, coverage for delivery, or quality of health and related services, including a complaint regarding an adverse determination made pursuant to utilization review, claims payment, or reimbursement for health care services, or matters pertaining to the contractual relationship between a member or a provider and UFBOT, through Ped-I-Care.

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

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 provide health related services in his/her designated area of practice, profession, or discipline.

Health Care Provider - A health care professional, health care facility, or entity licensed or certified to provide health services in this state.

Health Services - The prevention, diagnosis, and treatment of human disease, pain, injury, deformity, or disabling conditions. (Chapter 391, F.S.)

HEDIS – Healthcare Effectiveness Data Information Set developed and published by the National Committee for Quality Assurance (NCQA). HEDIS includes technical specifications for the calculation of performance measures.

Hospital - A facility licensed in accordance with the provisions of Chapter 395, F.S., or the applicable laws of the state in which the service is furnished.

ICS Network Provider(s) - CMS Pan approved and UFBOT-contracted participants in Ped-I-Care Provider Network, that have agreed to serve as in-network providers and to provide covered services to members as required by and in compliance with the terms of this contract and their UFBOT ICS Network Participation Agreement.

Integrated Care System (ICS) - A comprehensive contracted program of health and related services for children with special health care needs. This is the core service delivery structure of CMS Plan. The ICS for this contract is known as Ped-I-Care, and is further identified and described on page 1 of Attachment I this contract.

Medicaid – The medical assistance program authorized by Title 19 of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency for Health Care Administration under 409.901 F.S.

Medical Home – A model of organization of comprehensive primary care managed and coordinated with a primary health care provider that integrates medical, behavioral, emotional and developmental services for children and adolescents with a family-centered focus and provides for continuity as the child transitions from one setting to another.

Medically Necessary or Medical Necessity – Services that include medical or allied care, goods, or services furnished or ordered to 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 confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not to be experimental of investigational;
d. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker, or the provider.

Member – A CMS Plan enrollee assigned to Ped-I-Care by the Department to receive services provided by UFBOT, through Ped-I-Care or arranged by UFBOT, through Ped-I-Care, to be provided, pursuant to this contract.

Member Services – Services provided by UFBOT, through Ped-I-Care's Member Services Department, so enrollees are notified of their rights and responsibilities; the role of Primary Care Physicians; how to

obtain care; what to do in an emergency or urgent medical situation; how to pursue a complaint, appeal, or grievance; how to report suspected fraud and abuse; procedures for obtaining required behavioral health services, including any additional ICS telephone numbers to be used for obtaining services; and all other requirements and benefits of the Ped-I-Care program.

Network Provider - A person or entity eligible to provide CMS Plan services and has executed an ICS Network Provider Participation Agreement with UFBOT, for the benefit of Ped-I- Care, to provide Covered Services to Ped-I-Care members.

NCQA - The National Committee for Quality Assurance is a private, not-for-profit corporation dedicated to assessing and reporting on the quality of managed care plans.

Outpatient - A patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

Ped-I-Care – The registered fictitious name of the integrated care system (ICS) program established by and under the auspices of the University of Florida College of Medicine's Department of Pediatrics and the supervision and control of The University of Florida Board of Trustees.

Peer Review - An evaluation of the professional practices of a provider by peers of the provider in order to assess the necessity, appropriateness, and quality of care furnished as such care is compared to that customarily furnished by the provider's peers and to recognized health care standards.

Portable X-Ray Services - X-ray services provided using equipment transported to a setting other than a hospital, clinic, or office of a physician or other practitioner of the healing arts.

PPEC – Prescribed Pediatric Extended Care is a nonresidential health care center for children who are medically complex or technologically dependent and require continuous therapeutic intervention or skilled nursing services.

Primary Care - Comprehensive, coordinated and readily accessible medical care, including health promotion and maintenance, treatment of illness and injury, early detection of disease and referral to specialists, when appropriate.

Primary Care Physician (PCP) - A CMS Plan participating physician with board certification who meets CMS Plan credentialing standards practicing as a family practitioner, pediatrician, or other specialty approved by the Department, who furnishes primary care and patient management services to a CMS Plan enrollee.

Prior Authorization - The act of authorizing specific services before they are rendered.

Private Duty Nursing – Skilled nursing services provided by an RN or an appropriately trained LPN which are provided in the member's home. These nursing services are under the direction and order of a licensed physician.

Protocols - Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem, or implementing a plan of medical, nursing, psychosocial, developmental, and educational services.

Provider - A person or entity that has a contractual agreement with UFBOT to provide services to Ped-I-Care members. This designation may include in-network and/or out of network providers.

Quality – The degree to which UFBOT, through Ped-I-Care, increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Improvement (QI) - The use and evaluation of measurable, meaningful, improvements to the delivery of patient care and services. It includes a clear rationale with study objectives relevant to the target population; a clear statement of purpose; appropriate data gathering methods; analysis of data; and strong and targeted action(s). (NCQA Quality Improvement Effectiveness Standards).

Quality Management - An eight step process that includes: understanding customer need; identifying processes and outcomes that meet customer need; assessing performance compared with professional or "best-of-class" standards; defining performance indicators; establishing performance expectations; monitoring and evaluating performance; reporting performance findings to providers and customers; and implementation of improvement strategies (The Managed Health Care Handbook by Peter R. Kongstvedt, 6th edition).

Regional Perinatal Intensive Care Center (RPICC) - A unit approved by the Department, located within a hospital, and specifically designed to provide a full range of health services to women with high risk pregnancies and a full range of newborn intensive care services which have been approved by the Department of Health (per enabling legislation Chapter 383, F.S.), and which meet the standards as defined in Chapter 64C- 6, Florida Administrative Code, for facilities, staffing and services.

Rural Areas - A county or area having a population density of less than 100 persons per square mile, or a county defined by the most recent United States Census as rural.

Screen or Screening - Assessment of a member's physical or mental condition to determine evidence or indications of problems and need for further evaluation or services.

Service Area - The designated geographical area within which UFBOT, for the benefit of Ped-I-Care, is authorized by this contract to furnish covered services to ICS members and within which the member resides.

Service Location – Any location at which a member obtains any health care service arranged by UFBOT, through Ped-I-Care, to be provided by health care providers to Ped-I-Care members under the terms of this contract.

Service Site - The locations designated by the ICS at which members shall receive primary care physician services.

State - State of Florida.

State Fiscal Year - The current fiscal year that encompasses July 1 through June 30.

Subcontract - An agreement entered into by UFBOT, for the benefit of Ped-I-Care, for provision of services on its behalf. Subcontracts include, but are not limited to the following: management or administrative agreements, including provision of mailing lists or direct mail services.

Subcontractor – Excepting providers in the Ped-I-Care Provider Network any person or entity to which UFBOT, for the benefit of Ped-I-Care has contracted or delegated some of its functions, services or its responsibilities under this contract.

Third-Party Administrator (TPA) – A firm that performs administrative functions as defined by an agreement, which usually includes claim processing and other functions. The CMS Plan TPA is MED3OOO. MED3OOO will process electronic files for eligibility and enrollment, care coordination, prior authorization and claims payment for CMS Plan.

Title 5 - A title of the federal Social Security Act that addresses services to children with special health care needs, women, infants, children, and adolescents.

Title 19 - A title of the federal Social Security Act relating to Medicaid.

Title 21 - A title of the federal Social Security Act relating to the provision of health insurance to low-income children.

Transportation - An appropriate means of conveyance furnished to a CMS Plan enrollee assigned as a member to Ped-I-Care to obtain authorized services.

Urgent Care – Services for conditions, which, 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.).

Well Care Visit – A routine medical visit for one of the following: Child Health Check Up visit, family planning, routine follow-up to a previously treated condition or illness, adult physical or any other routine visit for other than the treatment of an illness.

TITLE XXI
ICS HEALTH CARE PROVIDER PARTICIPATION AGREEMENT

This Agreement (Agreement) is entered into by and between Provider and The University of Florida Board of Trustees (University), for the benefit of the Ped-I-Care Program, Department of Pediatrics, College of Medicine, University of Florida.

University, a public body corporate of the State of Florida, pursuant to Section 1001.72 Florida Statutes, and having an academic medical/health center, existing pursuant to Section 7, Article IX of the Constitution of the State of Florida, is charged with a tripartite mission of service, education and research; and University enters into agreements in support of its educational programs and service mission.

The State of Florida Department of Health Children's Medical Services (CMS) has entered into an agreement with University, pursuant to which University has established a Pediatric Integrated Care System (ICS), also known as Ped-I-Care, which will provide or arrange to provide a specified array of health care services (Covered Benefits) to children with serious and chronic health care needs who qualify for services under Title XXI of the Social Security Act (Members).

University and Provider enter into this Agreement for Provider to provide health care services, as defined in the attached and incorporated health care services attachment(s) (Services Attachment(s)), to Members as a participating Provider in University's ICS Provider network in compliance with the terms of the University/CMS contract, and as directed by University.

University enters into this Agreement on the behalf of its Ped-I-Care program. The parties understand that all references to the term "Ped-I-Care" when used hereafter in this Agreement shall refer to The University of Florida Board of Trustees, for the benefit of the Ped-I-Care Program, Department of Pediatrics, College of Medicine, University of Florida, and that all rights, duties and obligations described in this Agreement, other than Provider's obligations, shall be attributed to University.

TERMS AND CONDITIONS

THE PARTIES HERETO AGREE AS FOLLOWS:

1. Term. The term of this Agreement will be for a period of one (1) year commencing on the Effective Date (Term). At the end of the initial Term and any subsequent Term, this Agreement automatically renews for successive terms of one year, unless earlier terminated.

2. Termination.
   a) *Mutual Termination.* The parties may terminate this Agreement at any time by a termination letter executed by both parties.
   b) *Termination at Will*. Either party may terminate this Agreement by giving at least ninety (90) days prior written notice to the other party. The notice shall specify the date on which such termination shall become effective.
   c) *Termination by Ped-I-Care*. Ped-I-Care shall have the right to immediately terminate or suspend this Agreement
      - if Provider has been terminated or suspended from participation in the CMS Program or has been charged or convicted of Medicare or Medicaid fraud, or other professional misconduct or criminal conduct;
      - if Provider is in violation of any provision of this Agreement, including but not limited to inadequate performance by Provider, and fails to come into compliance with this Agreement within fifteen (15) calendar days of Ped-I-Care's notice specifying the

violation;

- if Provider's violation poses an immediate risk to the health or well-being of Members.

Immediate terminations may be made verbally or by electronic medium, but a written notice shall follow.

d) *Effect of Termination*. Termination of this Agreement shall not affect any rights or obligations of the parties hereunder which shall have previously accrued, or shall thereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Agreement. If the Provider is currently treating Members at time of termination, Provider shall comply with Ped-I-Care policies regarding the continuity of patient care and the transfer of patient records, including but not limited to the immediate arrangement for transfer of a Member to an alternate appropriate provider if the Member's health and safety is in jeopardy; and to cooperate in all respects with such alternate provider to assure maximum health outcomes for Members. Termination of this Agreement by Provider and/or Ped-I-Care in no way binds the State of Florida nor precludes the State of Florida from taking further action.

3. Participation Criteria. To participate in the Ped-I-Care Provider network, Provider must meet all of the appropriate criteria set forth in the then current CMS policies and procedures (http://www.cms-kids.com/providers/providers.html). If Provider is a licensed health care provider, Provider must meet the approval (and re-approval) criteria set forth in the then current CMS approval policies and procedures, and must maintain status as a CMS approved provider throughout the term of this Agreement. If applicable, Provider shall secure and maintain admitting privileges in good standing at a hospital contractually participating in the Ped-I-Care Provider network throughout the term of this Agreement, unless granted a waiver by CMS. CMS will perform the noted approval and reapproval pursuant to CMS' policies and procedures, unless CMS agrees to delegate CMS approval and CMS reapproval. Provider shall be notified of the outcome of the CMS approval process. Provider shall be a participating Provider only in the areas of practice or specialty for which Provider has been approved. A copy of the CMS provider approval policies and procedures will be provided to Provider upon request.

   Provider certifies that neither Provider, nor any of Provider's employees providing services pursuant to this Agreement, has been disqualified, debarred, excluded, or otherwise determined ineligible for participation in any federally funded health care program.

4. Quality Improvement Program. Provider shall participate in the Ped-I-Care Quality Improvement Program (QIP), which requires biennial site visits by Quality Assessment (QA) staff and access to all Provider records pertinent to this Agreement, including patient records, by Ped-I-Care's QA staff; as well as standardized charting in medical/health records and maintaining a comprehensive record, including results of referrals and other services rendered to Members. Provider shall also allow for possible inspections by Department of Health and Human Services (DHHS) and Agency for Health Care Administration (AHCA) to evaluate the quality, appropriateness and timeliness of services performed and all records pertinent to this Agreement, including patient records.

5. Non-Discrimination by Provider. Provider agrees: (a) not to differentiate or discriminate in its provision of services to Members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, disability or age; (b) to render services to Members in the same manner, in accordance with the same standards as offered to patients who are not Members consistent with existing medical/health ethical/legal requirements for providing continuity of care to any patient; (c) to comply with all provisions of the Ped-I-Care Cultural Competency Plan while providing services pursuant to this Agreement.

6. Maintenance and Confidentiality of Medical/Health Records. Provider agrees to maintain a standard medical/health records file, in a form and for the time period required by law for each Member to whom Provider provides Covered Benefits , and further agrees: (i) upon receipt of reasonable prior written notice, Provider shall facilitate inspection and copying of such medical/health records by CMS, Ped-I-Care, or applicable governmental agencies; (ii) upon termination of this Agreement, Provider agrees to cooperate with Members, CMS and/or Ped-I-Care, and subsequent providers, with respect to the orderly and prompt transfer of copies of a Member's medical/health records; (iii) not to dispose of any records mentioned herein without the prior approval of CMS and Ped-I-Care.

Provider shall maintain all patient protected health information ("PHI") generated and held in custody as a result of performance under this Agreement, including but not limited to Members' medical records, in a secure and confidential fashion, and not disclose such information to any third party, except as allowed or required by law. Consent and authorization to disclose Member's PHI shall be obtained from the legal representative of the Member in accordance with Sections 394.4615, 395.3025, and 456.057, Florida Statutes, as applicable, and disclosure shall be in accordance with any other applicable state and federal laws, e.g. the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Clinical Laboratory Improvements Act of 1988 ("CLIA"), or the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and shall be in compliance with the "minimum necessary" standards under HIPAA. Provider shall ensure PHI disclosed or received via any electronic medium (ex. facsimile, email, video) meets AHCA's security requirements.

7. Provider Manual. The Provider Manual, being a part of this Agreement and accessible to Provider at http://pedicare.peds.ufl.edu/providers/provider_manual.pdf, provides additional information, including but not limited to information about eligible services, Utilization Management, Billing and Claims Payment, Quality Improvement Plan, Grievance Procedure for Providers and Members, insurance requirements, out-of-network referral handling, benefits not covered by Ped-I-Care, and the current Ped-I-Care provider directory.

8. Claims. CMS has subdelegated claims responsibility to a third party administrator, MED3000 Health Solutions Southeast Region (TPA). Provider shall submit all invoices/claims on the appropriate Centers for Medicare and Medicaid Services claim form, or American Dental Association (ADA) form, as appropriate, in a HIPAA compliant format to the third party administrator (TPA) for purposes of the TPA paying such invoices/claims. Provider must submit invoices/claims within three hundred sixty-five (365) days of service delivery and must accurately provide all required information in order to be paid. If Provider wishes to resubmit or appeal a denied claim, that activity must be performed within sixty (60) days of Provider's receipt of the written rejection notice from the TPA. Invoices/claims not meeting the aforementioned guidelines may not be paid. Payment through the TPA will be considered payment in full. Authorization of services does not guarantee payment. **Provider shall not bill Members, their families, or legal representative(s) for Covered Benefits rendered pursuant to this Agreement**.

The process for filing electronic claims, which is the preferred method of claims' submission, can be found in the Provider Manual. If filing paper claims, Provider shall submit claims to:

MED3000 / CMS
P.O. Box 981733
El Paso, TX 79998

Provider shall maintain a record system to adequately record services, charges, dates and all other commonly accepted informational elements for services rendered to Members pursuant to this Agreement.

9. Professional Judgment. Nothing in this Agreement is intended to create, nor shall be construed to create, any responsibility or right in Ped-I-Care to intervene in the way in which Provider exercises independent professional judgment, or with the manner, method, or means by which Provider provides services to Members. Provider shall be solely responsible for all medical/health advice and medical or health related services Provider renders under this Agreement.

10. Amendment. The parties may revise this Agreement at any time by written amendment, signed by the legal representative of each party. All amendments shall be attached to and incorporated into this Agreement by reference. Notwithstanding the foregoing, Provider Information changes may be accomplished without formal amendment, but shall require written notification to Ped-I-Care.

11. Independent Contractors. Nothing in this Agreement shall be construed or deemed to create a relationship between or among Provider and Ped-I-Care of employer and employee or principal and agent, or any relationship other than that of independent contractors. Further, the parties expressly intend that no agent, servant, contractor, or employee of one party be deemed an agent, servant, contractor, or employee of the other party. By entering into this Agreement, neither party intends to accept liability to third parties for the acts or omissions of the agents, representatives, or employees of the other party.

12. No Third Party Beneficiary. Notwithstanding that some benefit may inure to other individuals or entities under this Agreement, it is not the intention of Ped-I-Care or Provider that such individuals or entities shall be third party beneficiaries of the obligations assumed by either party to this Agreement, and no such individuals or entities shall have the right to enforce any such obligation, unless otherwise specified herein.

13. Notice. Any notice required by this Agreement shall be in writing and delivered with delivery confirmation by courier service, United States Postal Service mail, by hand delivery, or by electronic transmission.

14. Public Records, Annual Appropriations, Governing Law. a) Ped-I-Care is subject to the provisions of Chapter 119, Florida Statutes, which allow public access to documents, papers, letters, or other materials made or received by the parties in conjunction with this Agreement. Notwithstanding the foregoing, there is an exemption to public access requirements afforded to patient records, pursuant to Section 456.057 (10)(a) Florida Statutes. b) Ped-I-Care's performance and obligation under this Agreement are contingent upon an annual appropriation by the Florida Legislature. c) This Agreement shall be governed by, enforced, and interpreted in accordance with the laws of the State of Florida.

15. Pharmacy. Members access out-patient pharmacy services through the Pharmacy Benefits Manager (MedImpact) under contract with the State CMS Office by contacting the member's CMS nurse coordinator. Covered medications, infusion products, injectables, nutrition supplements and other prescribed drug services are to be obtained through the CMS Pharmacy Benefits Management Program (PBM), MedImpact. If specialized products, such as injectables and infusion products are not included in the PBM Program, arrangements should be made with the CMS Area Office. Only pharmaceuticals approved for use by CMS will be covered. Information on which medications are covered and which pharmacies are included in the network can be found at web site: www.doh.state.fl.us/cms/PharmBM.html.

16. Regulatory Compliance. Provider shall comply with a) all applicable federal, state, county, or

municipal statutes or ordinances; b) all applicable rules and regulations of the Florida Department of Business and Professional Regulation and/or of the appropriate health profession's Board within the Division of Medical Quality Assurance of the State of Florida Department of Health; c) the ethical standards of the appropriate entity to which Provider is under ethical purview; d) any investigation by any state or federal entity or any subsequent legal action that may result from such an investigation; e) the Pro-Children Act of 1994, Public Law 103-277 (no smoking around children); and f) the Deficit Reduction Act of 2005(DRA 2005), inclusive of the policy found at: http://www.med.ufl.edu/complian/debt_reduction_2005.html. Information regarding DRA2005**,** the federal and the Florida False Claims Acts, false claims' penalties and whistleblower protection can be found at the foregoing website and in the Provider Manual.

17. Utilization Management. Provider shall comply with the Ped-I-Care Utilization Management (UM) Program. Compliance requires (a) use of Ped-I-Care network providers for primary care, hospital, specialty and ancillary services, (bi) accepting the Ped-I-Care primary care provider's ("PCP's") role of gatekeeper by rendering services only upon referral of a Ped-I-Care PCP, or upon administrative authorization of Ped-I-Care, and (c) sending to the Ped-I-Care PCP copies of all records memorializing Member visits and results of procedures provided. The parties acknowledge that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member.

18. Financial Responsibility. Providers licensed as physicians pursuant to Chapter 458, Florida Statutes, or as osteopathic physicians pursuant to Chapter 459, Florida Statutes, or as advanced registered nurse practitioners pursuant to Chapter 464, Florida Statutes, shall maintain, at their sole cost and expense and through the entire term of this Agreement, financial responsibility as set forth in Section 458.320 (1) or (2), Florida Statutes, and Section 459.0085 (1) or (2), Florida Statutes, or sections 624.09, 626.914(2), 627.351(4), 627.357, or 627.942, Florida Statutes respectively.

19. Insurance. Provider shall secure and maintain during the life of this Agreement workers' compensation insurance complying with the Florida Workers' Compensation Law for all of Provider's employees connected with the services to be provided under this Agreement, and malpractice and comprehensive insurance, as applicable and more specifically described in the Provider Manual. Provider shall notify Ped-I-Care in the event of a lapse in any of the required insurances, or if the Provider's assets fall below the amount necessary for licensure pursuant to Florida law.

20. Sub-Contracting. If Provider subcontracts any of Provider's obligations under this Agreement: a) Provider must first give notice to and obtain consent from Ped-I-Care; b) subcontractors must agree in writing to all of the same restrictions and conditions that apply to Provider under this Agreement; and c) all subcontracts must include assurances that said subcontracts are signed by the authorized legal representative of each party thereto.

21. Liability. Unless Provider is a state agency or subdivision, as defined by Section 768.28, Florida Statutes, or is a public health entity with sovereign immunity, Provider is liable for, and indemnifies, defends and holds AHCA, CMS, Ped-I-Care, and/or Members harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, proximately caused by any negligent act or other wrongful conduct arising from this Agreement. AHCA, CMS, Ped-I-Care and/or Members will not be held liable for any debts of Provider. This clause survives the termination of this Agreement, including

breach of contract due to insolvency.

22. Counterparts/Authorized Signor. This Agreement may be executed in counterparts, which together will be one and the same Agreement. Counterparts may be exchanged by facsimile or by electronic delivery if mutually agreed to by the Parties. Each signer warrants that he/ she is authorized to sign on behalf of his/her party named on the signature page.

23. E-Verify Requirement. Provider agrees to utilize the U.S. Department of Homeland Security's E-Verify system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all persons employed or assigned (including subcontractors) during the Agreement term by the Provider to provide healthcare services to ICS members. Upon reasonable notice, Provider will provide Ped-I-Care with the verification results. Pursuant to the Immigration and Naturalization Act (8 USC 134) and Section 101 of the Immigration Reform and Control Act of 1986, Provider shall not employ unauthorized aliens.

24. Health Care Professionals. Provider shall provide Ped-I-Care with a complete list of its healthcare professionals and their credentials prior to the execution of this Agreement, inclusive of group practice members or employees (do not include on-call substitutes) who are to be designated as Participating Providers and physician extenders who may participate in provision of care in connection with this Agreement.

Provider shall notify Ped-I-Care immediately in writing if a healthcare professional is leaving Provider's employment, or if a new healthcare professional is being hired by Provider. Such Provider notice shall include the healthcare professional's full name, degree or qualification, and the date of engagement or disengagement, as the case may be.

Provider hereby represents and warrants that Provider, including all of the Provider's healthcare professionals, as reported in accordance with this Section 24, meet the professional qualifications specified by the Agency for Health Care Administration (AHCA). Provider shall be considered as a participating provider only in the field(s) in which Provider has documented the appropriate qualifications.

This section 24 is not applicable to providers who provide only hospital/inpatient/residential care services to Members.

25. Additional Terms Specific to Provider.

TITLE XXI
ICS HEALTH CARE PROVIDER PARTICIPATION AGREEMENT

Provider Information and Agreement Signature Page

I. EFFECTIVE DATE: [Insert Effective Date]
II. PROVIDER:

[Insert Complete Legal Entity Name]
Complete Legal Name

[Insert Tax ID# or NPI#]
Tax ID Number or NPI Number
(Please **do not** provide a social security number.)

III. Provider's Address Information.

Practice Sites: List applicable practice sites (may attach additional sheets).

Practice Site Name	**Address**
[Insert Practice Site Name]	[Insert Practice Site Address]

Provider's Address for Notices:
[Insert Notice Address]

Provider's Address for Payments:
[Insert Payment Address]

IV. Services: [Insert Services (Primary Care, Specialty, etc.) ([Insert Attachment Name(s)])

In the event ANY OF THE ABOVE INFORMATION IS INCORRECT OR CHANGES, Provider agrees to *immediately* notify Ped-I-Care in writing of such changes.

V. Ped-I-Care's Address for Notices: Ped-I-Care, 1701 SW 16th Ave., Bldg. A, 3rd Floor, Gainesville, FL 32608. The facsimile number for notices is: 352-955-6518.

VI. Entire Agreement. This Agreement, together with the Terms and Conditions, incorporated attachments, and referenced ancillary documents, such as the Ped-I-Care Provider Manual, and all applicable Florida Medicaid Handbooks ("Handbooks"), represents the entire agreement between Ped-I-Care and Provider, and supersedes all representations, understandings, or agreements, oral or written, made prior to the execution of this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed for the purpose herein expressed to be effective as of the day and year first above set forth.

(PROVIDER) **[INSERT COMPLETE LEGAL ENTITY NAME]**	**The University of Florida Board of Trustees, for the benefit of the Ped-I-Care Program, Department of Pediatrics, College of Medicine, University of Florida**
By:	By:
[Insert Name Of Authorized Signer] [Insert Title Of Authorized Signer] [Insert Complete Legal Entity Name]	Michael L. Good, M.D. Dean, College of Medicine University of Florida

TITLE XXI

ICS HEALTHCARE PROVIDER PARTICIPATION AGREEMENT

ANCILLARY SERVICES ATTACHMENT

1. Fee Schedule.

   CMS, through the TPA, will pay Provider the prevailing Florida Medicaid rate as applicable for all allowable services, as described by Medicaid and which follow Ped-I-Care authorization and utilization management policies and procedures.

2. Services.

   Provider shall provide ancillary care services to Members. Services are those Covered Benefits included in the Florida Medicaid Benefit Package. Refer to Florida Medicaid Handbooks for specific requirements.

   If applicable, Applied Behavioral Analysis (ABA) Providers shall provide ABA services to Members who are enrolled in Ped-I-Care. A Board Certified Assistant Behavior Analyst (“BCaBA”) must have required supervision of a Board Certified Behavior Analyst (“BCBA”) or a Board Certified Behavior Analyst, Doctorate (“BCBAD”).

TITLE XXI

ICS HEALTH CARE PROVIDER PARTICIPATION AGREEMENT

HOSPITAL/INPATIENT FACILITY SERVICES ATTACHMENT

1. Fee Schedule.

   CMS, through the TPA, will pay Provider the prevailing Facility specific Florida Medicaid rate for all Medicaid allowable services, provided according to the Florida Agency for Health Care Administration Medicaid Guidelines outlined in the Medicaid Hospital Provider and other applicable Handbook(s) and according to the Ped-I-Care authorization and utilization management policies and procedures.

2. Licensed Hospital/Inpatient Facility.

   Provider warrants that it is a Hospital/Inpatient Facility licensed by the State of Florida. Provider shall be under a continuing obligation to maintain current licensure and, as applicable, accreditation consistent with such licensure. Participation under the Agreement shall be contingent upon Provider supplying CMS with evidence of current licensure and other relevant documentation.

3. Health Care Staff.

   Provider acknowledges and agrees that Provider provides inpatient and/or residential services at its owned and/or operated hospitals and facilities, and provides professional health care services through its employed and contracted healthcare professionals. Provider 's health care staff who will provide services in the Provider's Facility (ies), and physicians who might be requested to provide professional consultation for Members shall be appropriately licensed, certified, or otherwise authorized in or by the State of Florida, and shall be credentialed, if so required by Provider. Provider's credentialing criteria shall be consistent with the standards of the appropriate accreditation body.

TITLE XXI
ICS HEALTH CARE PROVIDER PARTICIPATION AGREEMENT

SPECIALTY SERVICES ATTACHMENT

1. Fee Schedule.
   CMS, through the TPA, will pay Provider the prevailing Florida Medicaid rate as applicable for all allowable services, as described by Medicaid and which follow the Ped-I-Care authorization and utilization management policies and procedures.

2. Services.
   Provider shall provide specialty physician services, only in the areas of practice or specialty for which Provider has been approved, to Members who are enrolled in Ped-I-Care. Specialty physician services are those Covered Benefits included in the Medicaid Benefit Package. Refer to Florida Medicaid Handbooks for specific requirements.