TITLE XIX

BROWARD COUNTY

PROVIDER MANUAL

P.O. Box 460512, Ft Lauderdale, FL 33346 ❖ Tel: (800) 988 5640 ❖ Fax: (954) 767 5604

WELCOME

We are pleased to welcome you as a network provider in the Children's Medical Services Network-Broward (CMSN-BROWARD). The Children's Medical Services Network-Broward is a partnership formed by the South Florida Community Care Network (SFCCN) and the Florida Department of Health – Children's Medical Services. The South Florida Community Care Network consists of three governmental entities: Memorial Healthcare System (MHS) in South Broward, Broward Health in North Broward and the Public Health Trust (PHT) in Miami-Dade County.

As an Integrated Care System (ICS), CMSN-BROWARD will provide medical services to eligible Florida Medicaid recipients. You have chosen to become a provider of this very unique network. Together we will work with you as a team, bringing our individual expertise to achieve the high standards our community expects. We will endeavor to provide quality coordinated care to the children with special health care needs covered under Title XIX of the Social Security Act, through Medicaid reform in Broward County.

You have committed to delivering quality medical care to CMSN-BROWARD enrollees. This Provider Manual answers many of your questions about the ICS and how it works. Outlined in this Provider Manual are the policies, procedures, and programs you have agreed to comply with, as presented in the Provider Services Agreement between you and CMSN-BROWARD. We are requesting your expertise to ensure that the care provided to the enrollees meets the Performance Indicators outlined in this manual. Please review this material to better understand the importance of your role in the provision of services to CMSN-BROWARD enrollees and compliance with designated program requirements.

A quick reference phone contact list is included at the end of this Manual, for your convenience. We urge you to call the Provider Relations Services if you have any questions or wish further information about the program or policies contained in this Manual. Please note that this Manual and its contents are subject to change. We will make every effort to inform you of significant changes in our policies and procedures.

You are a key part in the inception of this first Children's Medical Service Integrated Care System (ICS) in the State of Florida. We look forward to a mutually satisfying relationship.

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CMS covered services for enrollees shadow the benefits and limitations within the State of Florida Medicaid Program (refer to the "Medicaid Coverage and Limitations Handbooks" for specific information). These handbooks may be ordered from the Medicaid fiscal agent or can be accessed on the AHCA website.

CMS covered services include:

- Health Assessment Screening
- Physical Exams: routine and chronic disease check-ups
- Well Child Care and Immunizations
- Lab and X-ray Services
- Therapies Services (Occupational, Physical, Respiratory, Speech)
- Home Health Services
- Durable Medical Equipment

Well Child Care (for enrollees under 21 years of age) includes:

Hearing and vision
Dental services
Health and development history
Routine immunizations and collecting a complete immunization record
Referrals for further diagnosis and treatment as needed
Therapy services when necessary

Maternity Care:

All pregnant enrollees will be offered a choice of a participating obstetrical doctor or nurse midwife for prenatal care and delivery of the newborn. All women of childbearing age will be provided counseling, testing, and treatment of blood-born diseases that may affect them or their unborn child.

Emergency Care:

Emergency Services are those necessary to treat a condition, illness, or injury threatening life or limb, which requires immediate attention. Emergency services also apply to behavioral health. Authorizations are not required for emergency care to be rendered.

Hospital Inpatient Care:

Includes all inpatient services authorized by the CMSN-BROWARD Network: room and board, nursing care, medical supplies, diagnostic and therapeutic services. There is no annual forty-five (45) day cap on inpatient care, pursuant to the Medicaid Benefits for children under 21 years of age.

Hospital Outpatient Care:

Includes all diagnostic and therapeutic services provided on an outpatient basis at a participating hospital or outpatient facility by a participating specialist. There is no per annum cap on outpatient services pursuant to Medicaid Benefits for children under 21 years of age.

Hearing Services:

CMS Title 19 follows service limitations identified in the Medicaid Hearing Services Coverage and Limitations Handbook. Medicaid may reimburse for one hearing aid, per ear, per recipient every three (3) years if criteria is met. In addition, Medicaid will reimburse for one fitting and

dispensing fee per recipient, every three years from the date the last hearing aid was ordered. Some exceptions are granted. Please refer to the Medicaid Handbook.

Behavioral Health:
For mental health and substance abuse services; the current Medicaid benefits apply.
University of Miami Behavioral Health (UMBH) provides behavioral health services. The covered services include:

- Inpatient and outpatient psychiatric hospital services
- Psychiatrist, psychologist and therapist services
- Community Mental Health services
- Mental Health Case Management

Emergency Room care and/or outpatient behavioral health services provided through participating Community Mental Health Centers do not require prior-authorization.

To coordinate behavioral health services, please contact UMBH at **800-294-8642.**

Vision Care:
Includes eye examinations by a certified participating optometrist necessary for fitting of glasses (eye exam and two (2) pairs of glasses per enrollee per year), contact lenses and follow-up examinations.

Family Planning:
Informational and referral
Education and counseling
Diagnostic testing
Contraceptives
Follow-up care to assist with spacing births
Assistance in determining problems related to infertility
Medically necessary sterilization

Pharmacy Services:
Covered drugs, injectables, nutritional supplements and other prescribed drug services are described in the Prescribed Drug Services Coverage and Limitations Handbook. Only pharmaceuticals covered by Medicaid and those that are FDA approved may be prescribed. Medicaid Preferred Drug List information can be accessed at http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/pharma_thera/fmpdl.shtml.
Enrollees may use any pharmacy that accepts Medicaid for their pharmaceutical needs and prescriptions services.

Medical Transportation Services:
Emergency and non-emergency transportation services are provided based on medical necessity.
To coordinate medical transportation, please contact LogistiCare at 866 250 7455.

Advanced Registered Nurse Practitioner (ARNP) Services
Ambulatory Surgical Services
Behavioral Health Services
Birthing Center
Child Health Check-Up
Chiropractic Services
Clinic Services
Community Mental Health Services
County Health Department Services
Dental Services
Diagnostic Studies and Testing
Durable Medical Equipment (DME) and Medical Supplies
Dialysis Services
Emergency Room Services
Family Planning
Federally Qualified Health Center (FQHC)
Hearing Services
Home Health (HH) Services
Hospice
Hospital Inpatient
Hospital Inpatient > 45 days
Hospital Outpatient
Immunizations
Lab and X-ray
Licensed Midwife Services
Medical and Surgical Services
Medical Transportation
Nuclear Medicine Services
Nutritional Services
Optometric Services
Personal Care Services
Pharmacy Services
Physician Assistant Service
Physician Services
Podiatry Services
Portable X-ray Services
Prescribed Drugs
Prescribed Pediatric Extended Care Services (PPEC)
Private Duty Nursing
Radiology Services
Regional Perinatal Intensive Care Centers (RPICC)
Rural Health Services
School Based Services
Skilled Nursing Facility (SNF)
Therapies: Physical, Occupational, Respiratory, Speech
Transplant Services
Vision Services

ENROLLEE SERVICES

The primary responsibility of the Enrollee Services is to facilitate and guide enrollees in accessing health care service and information about CMSN-BROWARD. Enrollee Services focuses on:

- Orientation and education of new enrollees about CMSN-BROWARD
- Answering eligibility questions
- Providing information on covered and non-covered services
- Educating enrollees on CMSN-BROWARD processes and services
- Providing referral/authorization status
- Providing enrollment status
- Directing enrollees to appropriate departments/resources
- Facilitating enrollee access to services
- Receiving/investigating/resolving and documenting complaints
- Analyzing/trending complaints for improvement
- Logging grievances received and forwarding them to the Grievance Coordinator
- Using enrollee feedback to improve quality of services and customer satisfaction

If for any reason an enrollee becomes dissatisfied with the assigned Primary Care Provider (PCP), services, and/or location, the enrollee may request a PCP change at any time by notifying Enrollee Services. The effective date of the change will depend on the day of the month the change is received but generally it will be the first business day of the following month.

Enrollee Services is available from 08:00am to 7:00pm, Monday to Friday. The telephone number is:
866 209 5022.

For TTD/TTY assistance, enrollees should call Florida Relay at 711.

PROVIDER RELATIONS

Provider Relations Services are responsible to assist your office with the procedures required by CMSN-BROWARD. This would include, but is not limited to: new provider orientation, assistance with reporting requirements, educational overviews on CMSN-BROWARD compliance issues, on-site support, assistance with address and other practice changes, questions regarding: procedures, policies, reimbursement, and other program information.

Provider Education Specialists from Provider Relations Services conduct routine visits of our provider sites. During their visit, the Provider Relations Representative assesses the practice's total compliance with various regulatory and program standards, including: access to care; physical accessibility to the practice environment; medical record keeping practices; patient confidentiality procedures; physical appearance & adequacy of facility; appropriate staffing (medical and administrative); OSHA compliance; grievance procedures; and peer review procedures.

The Provider Relations Representatives are available to assist you with any of the services outlined above from 08:00am to 5:00pm, Monday through Friday by calling: **800 988 5640 or 954 767 5500.**

Provider Complaints

Should a participating provider become dissatisfied with CMSN-BROWARD's policies and procedures, or any aspects of CMSN-BROWARD's administrative functions, the provider may file a complaint with the Provider Relations Services. Complaints need to be filed within forty-five (45) calendar days of the

event. CMSN-BROWARD's' dedicated Provider Relations staff are available during regular business hours via telephone, electronic mail or in person to ask questions, file a complaint and /or resolve problems. The Provider Relations staff will carefully record and thoroughly investigate each complaint according to the established procedure using applicable statutory, regulatory, contractual and provider contract provisions, and will collect all pertinent facts from all parties.

In the event the outcome of the review of the provider complaint is adverse to the provider, CMSN-BROWARD will provide a written notice of adverse action to the provider. The notice will be issued within five (5) days of the determination. CMSN-BROWARD may require appropriate and timely corrective action from the provider(s) involved in the complaints, when warranted.

At least quarterly, the Quality Improvement Committee (QIC) will review aggregate data from provider complaints and trends identified will be addressed through appropriate remedial action and follow-up.

CARE COORDINATION and the CMS AREA OFFICE

In order to meet the health care needs of CMS children and their families and provide continuity and coordination of care across the health care spectrum and through the multi-disciplinary team approach, Care Coordination will be provided by the clinical professionals at the CMS Area Office in Broward.

A care coordinator is assigned to each CMS enrollees at the time of enrollment. The care coordinator will contact the family at the time of enrollment to initiate this service and will maintain regular contact with the enrollee/family as needed, thereafter. Families may opt out of care coordination if they feel they do not need this component of the program.

The care coordinator integrates all of the elements of each child's life related to his/her special health care needs, in coordination with the Primary Care Physician (medical home), the health plan and the family. The care coordinator is the critical link in obtaining the appropriate clinical care and services, social and emotional development of the child within the context of their family, school and the community.

In addition to care coordination, the CMS Area Office is responsible for the following functions:

- Determination of clinical eligibility
- Enrollment in the CMS network
- Provision of necessary specialty clinics
- Health education
- Nutrition education
- Social work services and counseling
- Coordination with community resources
- Family support
- Transition support.

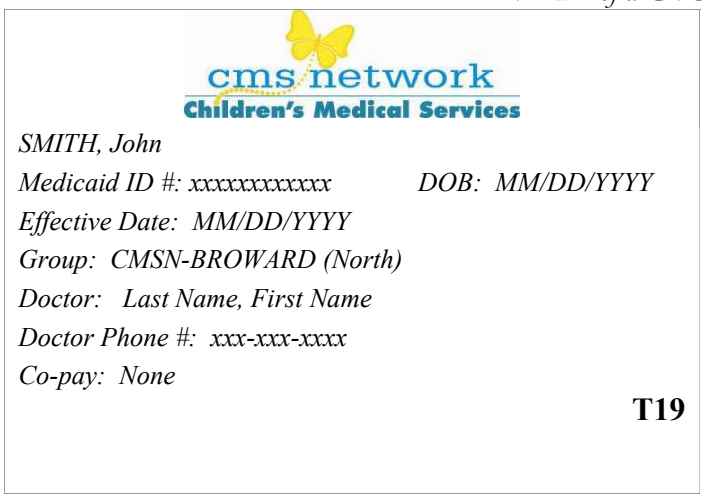
To contact the CMS Area Office-Broward, please call: **954 713 3100.**

ENROLLEE ID CARDS

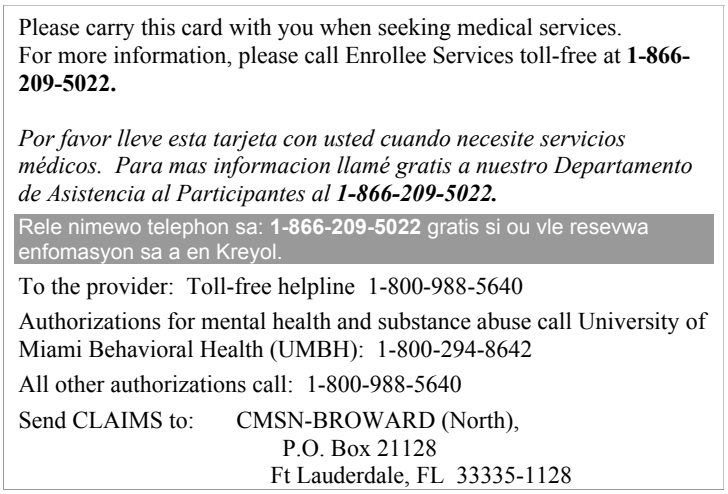
Each CMSN-BROWARD enrollee will receive a CMS identification card **(see example below)** which has valuable information on both sides. This is in addition to the (gold) Medicaid ID card issued by the State of Florida to every Medicaid recipient. Enrollees have been asked to carry their ID card at all times. The CMSN-BROWARD card provides additional information to providers, including:

- The name and phone number of the primary care provider or clinic to which the enrollee is assigned.
- Phone numbers for authorization of services and to report hospital admissions.

EXAMPLE of a CMSN-BROWARD ENROLLEE ID CARD



Enrollee ID Card – FRONT



Enrollee ID Card - BACK

VERIFICATION OF ENROLLMENT

All providers are required to verify eligibility prior to services being rendered. Eligibility needs to be verified even if a provider has a referral and authorization number. This can be done through the Medicaid Eligibility Verification System (MEVS) with various vendors available (swipe-card process) or through secured access to the Medicaid website -Medifax. The gold card furnished to enrollees by Medicaid is to be used (swiped) for MEVS checking of eligibility. For questions about eligibility verifications, please contact the Medicaid Fiscal Agent's toll-free provider inquiry line at: **800 289 7799**.

RESPONSIBILITIES - ALL NETWORK PROVIDERS

All network providers, through the terms of their participation agreement, are required to have a Florida Medicaid Provider number, cooperate with CMSN-BROWARD programs, maintain adequate business and confidential medical records, arrange for appropriate coverage, and to comply with CMSN-BROWARD's access to care standards, which are described in the Quality Improvement section of this Manual. The following is a summary of the requirements applicable to all CMSN-BROWARD network providers. For complete information regarding provider responsibilities, please refer to your individual participation agreement.

Confidentiality
All network providers are required to maintain the confidentiality of the enrollee's personal and medical record information as required by federal and State law.

Cooperation with CMSN-BROWARD Programs
All network providers are required to cooperate with CMSN-BROWARD's Medical and Utilization Management procedures; Health Management activities; Credentialing Process; Quality Improvement programs (including medical record audits and peer review activities); Claims and Reimbursement guidelines and Grievance procedures.

Demographic & Status Changes
It is imperative that you notify your Provider Relations Representative of changes in your practice, prior to the effective date of the change. This information is essential for Provider Directory revisions and ensures continuity of care to the enrollees. Demographic information includes your office address; telephone number; fax number; e-mail address; tax identification number; and billing address. Status information includes physicians joining/leaving your practice; and the opening or closure of additional practice sites.

Facilities & Environment
All network providers must maintain a safe and sanitary environment for their enrollees that are in compliance with state and local building codes, federal regulations and work safety requirements. Contracted providers should provide periodic safety instructions to all personnel including appropriate emergency response and use of related equipment. Since emergency situations occur with little or no warning CMSN-BROWARD encourages providers to develop an Emergency Management Plan to prepare their offices for any disaster.

In the event a disaster impacts your offices, operation or access to care for enrollees, notification to the Provider Relations Services is requested so we may assist enrollees.

Cultural and Linguistic Awareness
All providers are expected to be aware of the cultural backgrounds of the patients they serve and to be sensitive toward issues of cultural diversity and health literacy. Providers should post clear, multi-lingual signs in the reception area about the availability of linguistic services and services for the hearing impaired. Providers should also ascertain the information used for health education reflects the cultural background and the literacy of their patient population. Staff training should include information about cultural diversity, the importance of non-verbal communication in patient care, and identifying and addressing patients with health literacy issues. Providers need to ask each patient about their language preference and include the information in their medical record.

Termination as Service Provider
Providers may terminate the agreement he/she has with CMSN-BROWARD with or without cause by providing sixty (60) calendar days advance written notice of termination to CMSN-BROWARD.

CMSN-BROWARD will immediately act to terminate any provider from its network upon notification that the provider has been terminated or suspended from participation in the State of Florida Medicaid Program. Providers are required to provide continuity of treatment in the event the provider agreement terminates during the course of an enrollee's treatment by that provider, unless the enrollee's behavior is abusive or non-compliant.

Failure to comply with the terms and conditions of the provider service agreement and or failure to make reasonable efforts to correct substandard performance in a timely manner may result in CMSN-BROWARD terminating its agreement with the provider

Fraud and Abuse Reporting

CMSN-BROWARD actively attempts to prevent and identify suspected incidents of Medicaid fraud and abuse. All activities seen as fraud and or abuse will be reported to AHCA's Medicaid Program Integrity Unit (MPI) as appropriate and as needed. CMSN-BROWARD actively, prospectively, and retrospectively analyses the potential for an occurrence of fraud and abuse, and monitors for fraud and abuse using resources such as (but not limited to) claims, credentailing/re-credentailing, utilization management, quality management, and grievance/appeals. CMSN-BROWARD additionally routinely accesses and uses the Health and Human Services (HHS) - Office of the Inspector General's List of Excluded Individuals and Entities (LOEIE) to identify individuals excluded from participation in Medicaid, and therefore CMSN-BROWARD. Confidentiality will be maintained for the suspect person or entity, and all rights afforded to both providers and enrollees will be reserved and enforced during the investigation process. Each of CMSN-BROWARD's health/hospital system also has a fraud and abuse prevention plan. Providers must comply with all aspects of CMSN-BROWARD and its health system's fraud and abuse plan/ requirements.

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

1. The CMSN-BROWARD Compliance Officer for CMSN-BROWARD North at **(800) 988-5640.**

or

2. The Florida Medicaid Fraud and Abuse Hotline at **888 419 3456**

or

3. AHCA – The Inspector General, 2727 Mahan Drive, MS#4, Tallahassee, FL 32308

or

4. by electronic mail to: **http://ahca.myflorida.com/Executive/Inspector_General/medicaid.shtml**

PCP RESPONSIBILITIES

New Enrollee Processing

Each month, upon request, PCP's will receive a hard copy of CMSN-BROWARD Enrollment Report specific to his/her patient panel. You may also access enrollment via the Internet within the first week of each month.

Sibling family members under the age of 21 may enroll in this program when an eligible sibling is enrolled. Families may select the same PCP for all family members enrolled in CMSN-BROWARD.

To encourage enrollees to visit their PCP, Enrollee Services at CMSN-BROWARD will contact each new enrollee by mail through an introductory letter that includes the name, address, and phone number of the enrollee's PCP along with an enrollee ID card. The letter requests the enrollee make an appointment with his/her PCP for initial assessment. Also included will be additional information regarding CMS-benefits.

In addition to the contact by CMSN-BROWARD, PCPs should welcome their new CMSN-BROWARD enrollees and arrange for an evaluation visit as soon as possible within the first thirty-(30) days of enrollment. The enrollee would have received in his/her eligibility/enrollment process from the CMS office, a health assessment form that is completed at the time of enrollment. Once completed, the CMS care coordinator will review it to identify any special health care need for the enrollee to be followed by the CMS care coordinator. A copy of the original form with valuable information will then be forwarded to you for review, action, and final placement in the enrollee's medical records. If you have not already initiated a

medical record for the enrollee, this is the opportunity. Be sure to document any attempts to reach the enrollee in the enrollee's medical record.

At the first visit, enrollees should be requested to authorize the release of their medical records. Once you receive a copy of the enrollee's medical record, you should identify those children who have received past screenings (Child Health Check-ups or EPSDTs) according to the Agency for Health Care Administration/Children's Medical Services/Department of Health approved schedules. Having knowledge of the enrollee's past medical history and treatment facilitates continuity of medical care.

Non-Compliant Enrollees

PCPs have a responsibility to respond to enrollees who either fail to keep appointments or fail to follow a provider's plan of care as either can interrupt continuity of care and lead to a delay or failure on the part of the enrollee to get medical diagnosis or treatment. CMSN-BROWARD expects providers/provider sites to have a procedure for dealing with non-compliant enrollees and enrollee notification. While it is the enrollee's responsibility to keep appointments and to comply with the plan of care prescribed by the attending physician, the provider in turn has responsibilities when this does not occur. The enrollee needs to be notified of his/her non-compliance and the provider needs to document this activity in the enrollee's medical record whether done orally or in writing. CMSN-BROWARD will be monitoring this activity.

"Failure to show" is defined as an enrollee who has missed three (3) consecutive appointments with the same health care provider or facility and does not notify the health care provider that he/she is unable to keep the scheduled appointment. Notifying the assigned CMS care coordinator for "no show" or "failure to show" patients may allow the CMS care coordinator to assist with transportation issues, etc. to prevent future missed appointments.

"Failure to follow plan of care" is when an enrollee chooses not to comply with the prescribed plan of care. Providers need to make a reasonable effort to establish and maintain a satisfactory relationship with enrollees. The CMS care coordinator can play a major role in assisting the enrollee in compliance.

Removing an enrollee from the Panel (Termination for Cause)

When such a relationship cannot be established or a breakdown occurs, the PCP has the right to request to have the non-compliant enrollee removed from his or her panel. Such a request needs to be communicated to your CMSN-BROWARD Provider Relations Representative. Each case will be evaluated individually to ascertain if a change in PCP is an option or if there is a need for CMSN-BROWARD to initiate an involuntary termination request from the CMSN-BROWARD through CMS Administration and Medicaid Area 10 Office. The latter action by CMSN-BROWARD requires substantial reason and supporting documentation by the provider to justify the involuntary disenrollment. After oral and written notification by the provider, if the enrollee fails to correct the situation the PCP should notify, by certified mail, the enrollee and CMSN-BROWARD's Provider Relations Services of his/her request to terminate his/her relationship with the enrollee as the PCP. The PCP is obligated to continue providing care until the effective date of the change in order to facilitate transition of care. The PCP should instruct the enrollee to seek assistance from CMSN-BROWARD Enrollee Services Department at **866 209 5022**.

Requests to Close Panel

Primary Care Providers need to submit to CMSN-BROWARD, in writing, any requests to close their panel or to accept new enrollees. This letter needs to include the reason for the request and an estimated time frame for non-acceptance of enrollees. When the provider is ready to open

his/her panel, the provider must notify CMSN-BROWARD's Provider Relation Services in writing. Such request must be made no less than thirty (30) calendar days in advance of the effective date.

Advance Directives
Under Florida laws, enrollees or their family/legal guardian (enrollees under 18 years old) have the right to accept or refuse medical, surgical or behavioral health treatment and the right to formulate Advance Directives.

CMSN-BROWARD urges enrollees/families or legal guardians to discuss their rights to have Advance Directives with the Primary Care Provider. The PCP should place a copy of the Advance Directives in the enrollee's medical record.

BILLING AND PAYMENT FOR SERVICES

BILLING PROHIBITIONS
Provider shall accept payment made by the Medicaid fiscal agent, in accordance with the terms and conditions of the "CSMN-BROWARD Provider Agreement", as payment in full and accept no payment from CMS enrollees, the enrollee's relatives or any other person or persons in charge as the enrollee's designated representative, in excess of the Medicaid fee schedule.

In no event, including, but not limited to, non-payment by the fiscal agent, insolvency of ICS or termination of your Provider Agreement, shall the Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any enrollee or persons, acting on the enrollee's behalf, for contracted services pursuant to your Provider Agreement.

CO-PAYMENT COLLECTIONS
CMS enrollees utilizing in-network services have no co-payments.

PAYMENT FOR SERVICES
AHCA's fiscal agent will reimburse providers for correct, authorized, clean (HIPAA-compliant) claims according to the Florida Medicaid fee schedule for reimbursement of covered serviced provided to enrollees. Primary Care Providers, specialists and ancillary providers will receive payment at 100% of the current Florida Medicaid fee schedule.

The Agency or its fiscal agent will also reimburse out-of-area providers on this fee-for-service schedule for authorized services provided to CMS enrollees.

CLAIMS SUBMISSION
Providers shall submit all claims to CMSN-BROWARD and in accordance with the Florida Medicaid Program. It is requested that claims be received within sixty (60) days from the date of service. Claims submitted after a twelve (12) month period from the date of service will be denied. Providers are encouraged to submit their claims electronically. For more information on electronic claims submission, contact Provider Relations at **800 988 5640**. Claims should be submitted in a HIPAA-compliant format, using the appropriate form (CMS-1500, UB-04, ADA Dental Claim Form, etc.). Claims for Child Health Check Up (EPSDT) services must be submitted on a CMS-1500 form (The 221 Form is no longer used to bill for these services). Please ensure the CMS-1500 claim form contains the following information:

- Enrollee's name, DOB, Medicaid ID Number
- Date of Service
- Authorization number (if applicable)

- Diagnosis codes (ICD-9)
- Services rendered (CPT-4, DRG, Revenue code, etc.)
- Provider's full name
- Provider's Federal Tax I.D. (TIN) number
- Provider's National Provider Identification (NPI) number (effective May 2008)
- Provider's Billing name
- Provider's Billing address
- Provider's Telephone Number

Claim forms that are incomplete or missing information will not be processed for payment or may be denied by AHCA's fiscal agent. If you have questions about how to submit claims, please contact Provider Relations Services at **800 988 5640.**

Claims with Attachments

Please refer to the Medicaid Physician Coverage and Limitations Handbook for claims requiring attachments. These claims are to be submitted via paper, with the appropriate supporting documents, to the address listed below.

Billing Address

Providers are responsible for submitting clean (HIPAA-compliant), complete and accurate claims to CMSN-BROWARD, in hard copy form or any other approved format to the following address:

CMSN-BROWARD North
Claims Dept.
P.O. Box 21128
Ft Lauderdale, FL 33335-1128
Telephone: 800 988 5640 or 954 767 5500

Third Party Liability (TPL) Cases

It is the Provider's responsibility to notify CMSN-BROWARD if an enrollee has insurance coverage in addition to CMS enrollment. CMSN-BROWARD will then forward this information to the Florida Medicaid program for research.

INQUIRIES REGARDING CLAIMS PAYMENT

If you have inquires regarding claim payment or additional claim inquiries, please contact the Claims Department at the following address:

CMSN-BROWARD North
Claims Department
P.O. Box 21128
Ft Lauderdale, FL 33335-1128
Telephone: **800 988 5640 or 954 767 5500**

PROVIDER APPEALS

Appeals for claims denied by CMSN-BROWARD should be submitted to the claims address listed above. Please include the appropriate documentation to support your appeal.

PRIMARY CARE PHYSICIAN CLINICAL SKILLS

The following Primary Care Skill Set is a list of standards that have been reviewed and approved by your generalist peers, including pediatricians, internists, family physicians, surgeons and emergency room physicians.

Although this list of clinical skills or services is comprehensive, not every generalist will be able to comply with this list in its entirety. As an example, there are clinical skill sets that are not applicable to the pediatrician. Conversely, there may be eye conditions that the generalist may not feel comfortable caring for. However, it is the intention of this section to serve as a guideline, in broad terms, for the services that the generalist is expected to deliver within his or her capabilities.

I. ALLERGY

A. Elicit a thorough allergy history and make use of environmental controls before referring to an allergist.

B. Treat all seasonal allergies when duration of symptoms last less than six (6) weeks per year or when symptoms occur in two (2) seasons, but the duration of symptoms last less than four (4) weeks each time. Consider referral if unresponsive to treatment.

C. Treat chronic rhinitis aggressively with at least three (3) sequential medication programs. Consider consultation or referral if the problem is unresponsive to treatment.

D. Treat hives aggressively while seeking the cause. Consider consultation or referral if the urticaria persists over two (2) week's duration.

E. May administer maintenance immunotherapy injections as prescribed by an allergist consultant once allergy testing and the institution of immunotherapy injections have been completed.

F. Diagnose and treat acute and chronic asthma. Consider consultation or referral if the treatment is unsuccessful or if hospitalization is needed. If chronic steroidal therapy is needed, consultation or referral may also be considered.

II. CARDIOVASCULAR SYSTEM

A. Diagnose and initiate treatment for significant heart disease and determine, in a timely manner, if consultation or referral is appropriate.

B. Evaluate chest pain, murmurs, and palpitations.

C. Diagnose and treat hypertension, mild congestive heart failure, and stable angina.

D. Evaluate and treat coronary risk factors including diabetes, hyperlipidemia, hypertension, and smoking.

E. Diagnose and evaluate syncope. Consult if the enrollee has a known history of heart disease or the cause has not been identified and the enrollee has a recurrent episode.

III. DERMATOLOGY

A. Treat acne with appropriate topical astringents and antibiotics for at least three (3) months using at least three (3) modalities. Consider consultation or referral if the problem is not resolved with continuing therapy or improvement ceases.

B. Consider consultation or referral for severe cystic acne.

C. Treat recurrent acne with a regimen that has been successful in the past, whether originated by the Primary Care Physician or the dermatologist.

D. Diagnose common rashes and dermatoses and treat within appropriate therapeutic protocols. Refer if there has been an unsatisfactory response to treatment or for ophthalmic involvement with herpes.

E. Diagnose and treat common hair and nail problems and dermal injuries, if appropriately trained. Refer for extensive alopecia areata or hair loss associated with infection or systemic disease.
   1. Examples of common hair problems include fungal infections, alopecia as a result of scarring or endocrine affects and ingrown hairs.
   2. Examples of common nail problems include trauma, disturbances associated with dermatoses or systemic illnesses, fungal or bacterial infections and ingrown toenail.
   3. Examples of dermal injuries include ambulatory management of minor burns, suturing lacerations, and treatment of bites and stings.

F. Diagnose and treat actinic keratoses, if appropriately trained.
   1. Perform cryotherapy, if appropriately trained.

G. Identify and consider consultation or referral for suspicious pigmented lesions, large or complicated lesions, lesions in immuno-compromised enrollees, and lesions in high risk areas. This may include:
   1. Malignant melanoma **(always refer)**
   2. Dysplastic nevi **(biopsy or refer)**
   3. Basal cell or squamous cell carcinomas **(always refer)**
   4. Other suspicious lesions. Characteristics may include:
      a. Enlargement
      b. Irregular margins
      c. Color changes
      d. Bleeding
      e. Ulceration
      f. Itching or pain
   5. Lesions in high risk areas include:
      a. Head and neck
      b. Face and ears
      c. Genital area
      d. Burn scars

H. Educate the enrollee regarding the removal of certain lesions for non-diagnostic purposes. These may be considered cosmetic and, therefore, may not be covered. Examples of lesions that may be considered cosmetic include: Liver spots, spider veins, wrinkles, skin tags, uncomplicated cyst, flat asymptomatic warts, stable lipomas, seborrheic-keratosis, non-inflamed papillomas, hereditary hypertrichosis, tattoos, and non-changing pigmented lesions without special risk (vitiligo) and keloids.

IV. ENDOCRINE SYSTEM

A. Diabetes (Refer all newly diagnosed diabetics)
   1. Diagnose and manage stable insulin dependent and non-insulin dependent diabetes.
      a. Consider consultation or referral if unstable
      b. Consider consultation or referral if pregnant
      c. Consider referral to education programs at contracted locations for newly diagnosed enrollees, new users of insulin, diabetics who are pregnant, those who travel, children and their parents
   2. Managed uncomplicated hyperglycemia that does not require intensive insulin or pump therapy. If hospitalization is needed, consider consultation.
   3. Obtain consultations for:
      a. Coma not readily reversible by glucose
      b. Poor control manifested by recurrent hypoglycemia, marked hyperglycemia, or persistent elevation of glycohemoglobin

c. Consideration of intensive insulin or pump therapy
d. Annual ophthalmology evaluation and especially those less than optimally controlled
e. Development and progression of complications, including peripheral neuropathy, skin lesions, impaired renal function, and ischemic symptoms and/or findings
f. Routine podiatry care, if PCP unable to perform
g. Ketoacidosis

B. Thyroid Disorders
1. Diagnose and treat hypothyroidism and hyperthyroidism
a. Consider consultation for hyperthyroidism in pregnancy, involving the endocrinologist and obstetrician
b. Refer for radioiodine or surgical therapy if appropriate
c. Refer for symptomatic or moderately severe exophthalmos
d. Refer if not responding to treatment or if refractory to initial treatment
2. Diagnose multi-nodular goiter. If the enrollee requires thyroid suppression, consider referral to specialist.
3. Consult for solitary thyroid nodules for consideration of biopsy and/or surgery. However, prior to the referral, the PCP should obtain the initial work-up, i.e. thyroid scan, basic labs, etc.

C. Lipid Disorders
1. Diagnose and treat lipid disorders with diet and/or at least two (2) medications for a minimum of six (6) months. Refer if the enrollee has not responded within a six month time frame. Consider referring earlier if the hyperlipidemia is quantitatively severe or if atherosclerosis is known.

V. GASTROINTESTINAL SYSTEM

A. Diagnose and treat common GI conditions including esophageal and reflux disease, hiatal hernia, hyper acidic and duodenal ulcer disease, infectious diarrhea, protracted vomiting, functional bowel disease, obstruction, diverticulitis and peptic ulcer disease.
1. Refer to surgeon for suspected bowel obstruction
2. Refer any of the above conditions if:
a. The diagnosis is unclear
b. The symptoms do not respond to therapy
c. The condition is refractory to initial therapy
d. Refer if abnormalities are found, there is associated bleeding, weight loss, or malabsorption problems
e. Enrollee needs colonoscopy or gastroscopy

B. Initiate evaluation and diagnosis of liver disorders. Consultation or referral should be considered for undiagnosed hepatocellular disease or obstruction, for new or intractable ascites, or in the presence of fever.

C. Diagnose and treat enrollees with acute pancreatitis and those with chronic relapsing pancreatitis responding to conservative treatment. Obtain consultation or referral for those Enrollees with:
1. Initial episode of acute pancreatitis
2. Consider early surgical consultation if course of treatment is unfavorable or complicated.
3. Enrollees with malabsorption secondary to chronic pancreatitis.

D. Diagnose and treat symptomatic hemorrhoids. Refer if surgical intervention is required.

VI. GENERAL SURGERY

A. Diagnose symptomatic gallbladder disease
B. Perform clinical breast exams
    1. Aspirate breast cyst (if trained) and send to pathology.
C. Perform incision and drainage of simple soft tissue infections, if trained

VII. FEMALE REPRODUCTIVE SYSTEM

A. Provide pelvic exams and PAP smears for female enrollees, if trained
B. Diagnose and treat common GYN conditions including vulvovaginitis, sexually transmitted diseases, and may manage menstrual disorders such as dysmenorrhea or vaginal bleeding if appropriately trained. Consider consultation or referrals for the following:
    1. Vaginal warts
    2. GYN complaints unresponsive to medical management
    3. Complex or unusual cases
    4. Suspected or confirmed ectopic pregnancy
    5. Pelvic pain associated with abnormal vaginal bleeding
    6. Uncertain clinical diagnosis which would benefit from another opinion or laparoscopy
    7. Women for whom pregnancy would represent high risk for the mother or fetus **(should have pre-pregnancy counseling**)
    8. Moderate to severe endometriosis
C. Diagnose pregnancy and refer for Obstetrical care
D. Diagnose abnormal early pregnancy and refer for:
    1. Vaginal bleeding
    2. Threatened abortion
    3. Incomplete abortion
    4. Missed abortion
    5. Molar pregnancy
E. Provide contraceptive counseling and management
F. Diagnose pre-menstrual syndrome based on history and symptoms calendar, and manage with hormones, NSAIDS, diuretics and other symptomatic treatment as appropriate. Refer refractory cases.
G. Order screening mammogram according to an approved schedule Identify breast lumps and refer for surgical management

VIII. HEMATOLOGY

A. Diagnose and institute appropriate testing and treatment for iron deficiency anemia, macrocytic anemia, hemolytic anemia, and sickle cell anemia. Refer for:
    1. Hypochromicrocytic anemia not due to iron deficiency
    2. Anemia not responding to treatment
    3. Inability to identify the cause
    4. Complications of sickle cell anemia
    5. Spherocytosis, immune-hemolytic anemia, thrombotic thrombocytopenic purpura, acute hemolytic crisis, and hemolysis of unknown cause.
    6. Bone marrow exam
B. Recognize the anemia of chronic disease
C. Refer for:
    1. Suspected porphyria and hemochromatosis
    2. Unexplained polycythemia
    3. Pancytopenia
    4. Leukemia, myelodysplastic disorders, myeloproliferative disorders and lymphomas.

5. Severe neutropenia
6. Abnormal white blood cell morphologies
7. Undiagnosed splenomegaly, adenopathy, or hypergammaglobulinemia.

D. Primary Care Physician may participate with the oncologist in the management of chronic lymphocytic leukemia.

E. Recognize bleeding disorders and diagnose most platelet and coagulation disorders. Treat stable active abnormalities. Refer for:
1. Undiagnosed conditions
2. Initial management
3. Bone marrow exam

F. Identify the need for and administer transfusion of blood products.

IX. NERVOUS SYSTEM

A. Perform a neurological history and examination that includes a mental status examination evaluation of the cranial nerves, motor and sensory function, coordination, gait, and reflexes.

B. Diagnose and treat neurologic pain syndromes, including headaches and migraines, myofascial pain and TMJ syndrome, low back pain, lumbosacral disc disease and sciatica. Consider consultation or referral if:
1. There is a neurologic deficit present
2. Condition unresponsive to conservative measures
3. No improvement after six (6) weeks of therapy
4. Suspected intracranial disorder

C. Manage uncomplicated stroke and/or TIA

D. Evaluate syncopy and seizures. Refer for:
1. Initial consultation to confirm diagnosis and establish a treatment plan
2. Confirmed seizures
3. Recurrent seizures
4. Condition of drug toxicity
5. Considering discontinuing anti-convulsants

E. Consider consultation for:
1. Dementia
2. Intention tremor
3. Tic douloureux
4. Intractable neurological symptoms
5. Any condition in which the cause is unclear
6. Any condition in which there is an unsatisfactory response to treatment.

X. MUSCULOSKELETAL SYSTEM

A. Diagnose and treat low back pain and sciatica without neurological deficit. Consider consultation or referral if condition unresponsive to conservative measures and/or if no improvement after six (6) weeks of therapy.

B. Diagnose and treat common musculoskeletal medical and mild traumatic problems, sprains, and acute inflammatory conditions. Consider consultation and referral for:
1. Intractable problems
2. Fractures
3. Lock knee
4. Unstable or apparent ligament tears, especially if the standing x-ray shows joint narrowing or gross destruction of articular surfaces.
5. Severe sprains.

C. Diagnose and refer non-displaced fractures of the clavicle, scapula, humerus, radius, ulna, hand, fingers, pelvis, patella, fibula, metatarsal, and toes. Splints and slings will generally treat these fractures.

D. Manage chronic pain if consultation has ruled out surgery.
   1. Soft tissue injections by the Primary Care Physician (if trained) are encouraged when clinically appropriate.

E. Diagnose and treat common foot problems conservatively. Conservative care includes education about hygiene, proper cutting of toenails, and the treatment of corns and calluses including paring, chemical treatment (if trained) and education for home debridement by the enrollee. The enrollee should also be instructed in proper footwear, especially if the enrollee is diabetic or has peripheral vascular disease. Consider consultation or referral if:
   1. Suspect osteomyelitis, gangrene, or deep abscess
   2. Persistent intractable difficulty
   3. Post surgical problems
   4. Prosthesis or orthotic needs

XI. OPHTHALMOLOGY SERVICES

A. Perform thorough ophthalmology history including family history, symptoms and subjective visual acuity.

B. Perform a basic eye examination including distant, near and color vision testing, gross visual field testing by confrontation, alternate cover testing, physical examination including a direct fundoscopy without dilation, extra-ocular muscle function evaluation and red reflex testing in pediatric Enrollees.

C. Diagnose and treat uncomplicated ocular trauma including:
   1. Corneal or conjunctival abrasions
   2. Contusions of the eye

   Treatment should include fluorescein staining and patching.

D. Consider consultation or referral for:
   1. All corneal burns after initial irrigation.
   2. Embedded, metallic, central or unremovable foreign bodies.
   3. Lacerations of the cornea or sclera or deep lid lacerations
   4. Hyphema
   5. Irregular pupil
   6. Proptosis
   7. Edema
   8. Suspected retinal detachment or intraocular foreign body
   9. Sudden vision loss or change
   10. Persistent severe pain without cause
   11. Absent red reflex
   12. Pediatric Enrollees with disconjugate gaze or other ophthalmologic problems.
   13. Periodic examinations on diabetics over the age of 30 or those who are poorly controlled.
   14. Periodic examinations on Enrollees who are taking Plaquenil.
   15. Iritis

E. Diagnose and treat common eye conditions including viral, bacterial and allergic conjunctivitis, blepharitis, hordeolum, chalazion, small subconjunctivial hemorrhage and dacryocystitis. Consultation or referral recommended when:
   1. There is a high index of suspicion for Herpes
   2. Suspicion for Iritis
   3. Condition unresponsive to treatment within two (2) or three (3) days

XII. OTOLARYNGOLOGY SERVICES

A. Diagnose and treat tonsillitis and streptococcal infections. Consider consultation or referral if:
   1. Acute tonsillitis unresponsive to four (4) weeks of antibiotic therapy.
   2. Recurrent infections within three (3) documented episodes within four (4) months or six (6) within one year.
   3. Tonsillar hemorrhage
   4. Suspected tonsillar malignancy
   5. Prolonged or recurrent peritonsillitis/peritonsillar abscess

B. Evaluate and treat acute otitis media. Consider consultation or referral if:
   1. Infections are unresponsive to two (2) different antibiotic courses of care.
   2. Dizziness, facial weakness, mastoiditis, chronic draining ear or hearing loss.
   3. Tympanocentesis
   4. Acute otitis media in a child with compromised host resistance.
   5. Persistent painful bullae unresponsive to analgesic measures.

C. Diagnose and treat otitis externa. Consider consultation or referral if:
   1. Patient fails to improve within 4 to 5 days.
   2. Enrollee is a diabetic, immunocompromised, has herpes zoster persistent otalgia (refer immediately).

D. Treat acute and chronic sinusitis with up to two (2) courses of antibiotics. Refer if:
   1. Infection is totally unresponsive with 72 hours. Consider earlier referral if infection is in frontal sinusitis or with periorbital cellulitis.
   2. Symptoms that persist for 20 days or more
   3. Persistent headache
   4. Recurrent infections

E. Treat nasal obstruction and vasomotor allergic rhinitis. Consider consultation or referral if problem persists more than three (3) months.

F. Remove ear wax

G. Consider consultation or referral for Bell's Palsy, if diagnosis is unclear

H. Consider consultation or referral for acute hearing loss, for persistent hearing loss not attributable to fluid or wax, for parotid masses, for hoarseness persistent for more than three (3) weeks and for hemoptysis.

I. Diagnose and treat acute parotitis and acute salivary gland infections with antibiotics. Refer if:
   1. Suspicious for abscess, calculus or neoplasm
   2. Failure to respond to antibiotics within one week
   3. Recurrent infections

J. Perform indirect layrngoscopy, if appropriately trained and office is adequately equipped.

XIII. PULMONARY SYSTEM

A. Evaluate symptoms and findings including chest pain, cough, dyspnea, hyper somnolence, increased or decreased breath sounds, rales, wheezes, cyanosis or clubbing. Obtain pulmonary function test with or without bronchodilators as indicated.

B. Diagnose and treat common respiratory conditions including asthma, acute bronchitis, pneumonia, and COPD.

C. Consider consultation or referral for the following:
   1. Persistent pleural effusions not due to heart failure
   2. Unresolved pneumonia or recurrent pneumonia
   3. Hemoptysis- persistent or of suspicious etiology
   4. Lung mass
   5. Interstitial disease
   6. Sarcoidosis

7. Tuberculosis
8. Unusual infections
9. Respiratory failure
10. Poor response to treatment
11. Percutaneous lung biopsies, pleural biopsies or supraclavicular node biopsies
12. Acute lung injury
13. Suspected sleep apnea

D. Recognize opportunistic infections as possible manifestations of immunodeficiency

XIV. PSYCHIATRY

The Primary Care Physician should recognize mental illness and symptoms when seeing Enrollees in order to avoid excessive resource consumption for somatic symptoms when a psychiatric diagnosis is the underlying cause. Some of the functions of the Primary Care Physician may include:

A. Perform developmental and psychosocial histories and mental status examinations when indicated by psychiatric or somatic presentations. Important somatic presentations include: fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems.

B. Diagnose physical disorders with behavioral manifestation.

C. Make presumptive diagnoses of psychosis, major depressive disorders, other mood disorders including manic or hypo-manic episodes, dementia, substance abuse, eating disorders, anxiety disorders, attention deficit disorder and some other childhood disorders, adjustment disorders and personality disorders.

D. Institute psychopharmacological intervention, when appropriate, and adjunctive supportive psychotherapy for the conditions listed above.

E. Refer for the following:
1. Persistent substance abuse
2. Non-compliance with or abuse of psychopharmacological, prescribed or over the counter medication.
3. Psychotic disorder
4. Suicidal ideation, plan or intent, or depression with vegetative symptoms.
5. Severe disassociative disorders, severe eating or pain disorders, and post–traumatic stress disorders.
6. Suspected Attention Deficit Disorder (ADD) or Hyperactive Attention Deficit Disorder (HADD) if there is an unsatisfactory response to initial medication.
7. Enrollee request for consultation or persistent dysfunction without resolution of the presenting symptom

F. Provide maintenance medication management after stabilization by a psychiatrist or if long term psychotherapy continues with a non physician therapist.

XV. RHEUMATOLOGY

A. Diagnose and treat common rheumatologic conditions including non-specific musculoskeletal pain, bursitis, tendinitis, and osteoarthritis. Consider consultation or referral if:
1. Unresponsive after two (2) to three (3) months of therapy
2. Functional impairment exists
3. Intractable pain
4. Serious collagen vascular disease is found

B. Diagnose and treat acute inflammatory arthritic diseases. This includes aspiration and/or injections when medically appropriate and necessary, if trained and experienced. Consider consultation or referral if:
1. If unresponsive to treatment plan

2. To establish a long-term management plan of care
3. If not experienced in small joint injections
4. If surgical treatment is being considered

C. Diagnose and treat uncomplicated collagen diseases, cutaneous and systemic vasculitides. Consider consultation or referral depending on the extent and severity of manifestations or complications. These may include:
1. Condition refractory to initial treatments
2. Diagnostic uncertainty
3. Immunosuppressive treatment is needed to allow tapering of corticosteroids.
4. Temporal arteritis **(refer immediately)**

XVI. UROLOGY

A. Diagnose and treat both initial and recurrent urinary tract infections. Consider consultation or referral if:
1. Identified anatomical abnormalities
2. Persistent or recurrent infections despite chemprophylaxis
3. In enrollees with marked urinary frequency or irritability with negative urinalyses and cultures.

B. Diagnose and treat sexually transmitted diseases including appropriate tests for chlamydia and gonorrhea. Consider consultation or referral for:
1. Urethral stricture
2. Condition unresponsive to treatment
3. Complications

C. Evaluate hematuria, prostatism and prostatic enlargement, and scrotal or peritesticular masses. Consider consultation or referral if:
1. Hematuria is due to a mass or has abnormal cytology
2. Hematuria is unexplained and persistent or recurrent
3. Anatomic or neurologic abnormalities are identified
4. Condition unresponsive to treatment
5. Any condition suspicious for malignancy
6. Enrollee has a testicular mass
7. Enrollee has a hydrocele, spermatocele or varicocele that are large enough to cause intolerable symptoms
8. Cause unknown

D. Diagnose and treat prostatitis and epididymitis. Refer **immediately** if:
1. Acute onset in young males that suggests testicular torsion
2. Condition occurs post-vasectomy
3. Recurrent infections
4. No response to treatment

E. Diagnose and manage small renal calculi on an outpatient basis. Consider consultation or referral if:
1. The stone is greater that 4 mm
2. The stone is in the proximal portion of the ureter
3. Consideration of lithotripsy, stenting or surgical removal
4. Fever
5. Unresponsive to symptomatic treatment
6. Obstruction has occurred

F. Evaluate abnormal kidney function tests, incontinence, impotence and male factor infertility prior to a referral to a specialist. The evaluation for the specific condition may include, but not be limited to the physical exam, IVP, semen analyses, endocrine studies, etc.

XVII. VASCULAR SURGERY

A. Diagnose abdominal aortic aneurysms (A.A.A.) by examination and ultrasound. Consider consultation or referral if:
   1. Enrollee is symptomatic
   2. A.A.A. enlarging
   3. A.A.A. 5 cm or greater in diameter

B. Diagnose thoracic aneurysms by exam and appropriate diagnostic tests. Consider consultation or referral if:
   1. Aneurysm is 5 cm in diameter or greater
   2. Aortic insufficiency or dissection
   3. Enrollee symptomatic

C. Diagnose and treat venous disease. Refer for:
   1. Uncertain diagnosis
   2. Complications such as refractory stasis ulcers or embolization

D. Diagnose and refer for arterial problems such as gangrene, ischemic ulcers or ischemic pain at rest.

XVIII. Requests for Rehabilitative Services

The request for ongoing rehabilitative services (occupational, respiratory, physical and speech/language therapy) is generally made in two phases, the initial assessment and the treatment plan. A primary care or specialty physician will make the request for the initial assessment. If approved, the therapist will conduct the assessment and develop a proposed treatment plan. The plan must be approved by the physician, as indicated by his/her signature on the plan, but the actual request may be submitted by either the physician or the therapist. The requesting provider will be considered the physician.

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

Occupational Therapy and Speech/Language Therapy

Guidelines have been established to assist Occupational and Speech/Language Therapists in obtaining authorizations for initial and on-going services.

Occupational Therapy (OT) Authorization Guidelines

1. Overview

Occupational Therapy intervention includes evaluation and treatment of motor, perceptual, sensory processing, adaptive/self-help, and social/emotional deficits in order to optimize level of functioning, facilitate development, and improve occupational performance.

OT intervention includes, but is not limited to, therapeutic activities and procedures, functional activities including activities of daily living (ADLs), neuromuscular training, sensory integration, manual therapy techniques, the application of modalities requiring direct contact, and orthosis fitting and training.

2. Guidelines for OT Interventions

The OT evaluation report and subsequent 6 month OT re-assessment report will determine the client's eligibility for OT intervention.

To qualify a client for OT services:

a. Providers must utilize either comprehensive standardized or performance-based measures that assess sensory motor functioning; and,

b. Document (clinical findings) the evidence of occupational performance limitation as a result of deficits identified with the assessment measures.

Criteria for eligibility will be as follows:

a. Performance-based test: Greater than 25% delays in performance in two or more developmental skills including motor, perceptual, sensory processing, adaptive/self-help, and social/emotional development;

b. Standardized assessment: Greater than 1.5 standard deviations from the norm/mean; and

c. Clinical Findings: existence of sensory-motor deficits impacting client's occupational performance.

3. Authorization of OT Services

CMS/SFCCN will authorize services that are:

a. Meeting the criteria for eligibility described in section 2 (Guidelines for OT Intervention);

b. Medically necessary, and prescribed by a physician (MD or DO), advanced Registered Nurse Practitioner (ARNP), or physician assistant (PA);

c. Individualized and specific to the client's needs and disability accounting for the severity, intensity, and longevity of condition;

d. Developmentally appropriate;

e. Consistent with best practice interventions (evidence-based practice which include the use of the most appropriate assessment tools, skilled therapeutic procedures, and cost-effective interventions; and

f. Reflecting parental/caregiver's involvement with the identification, implementation, and delivery of services.

CMS will not authorize services that are:

a. Primarily educationally relevant;

b. Unsupported by client's progress in functional gains, occupational performances, and/or maintenance of quality of life and safety following OT intervention; or

c. Reflecting inappropriate and unrealistic outcomes that are inconsistent with client's diagnosis, overall prognosis, and rehabilitative expectations.

4. Plan of Care and Frequency of Therapies

A plan of care (treatment plan) will need to be submitted with the initial evaluation and subsequent six (6)-month re-assessments to describe:

a. OT procedures to be utilized;

b. Short term and long term goals;

c. Frequency of therapy (# units/week; 1 unit = 15 minutes); and

d. Projected outcome for therapy which will include functional level to be achieved by client to map discharge plan.

Guidelines for the utilization and delivery of therapy services will be as follows:

a. Intensive Therapy -Up to 12 units per week for new episode of acute illness for up to 6 months;

b. Moderate Therapy -Up to 9 units a week for chronic illness or pre-existent condition for up to 6 months;

c. Maintenance Therapy -Up to 6 units a week for developmental disability for up to 6 months; and

d. Consultative Therapy -Up to 6 units a month prior to dismissal for up to 3 months.

Speech /Language Authorization Guidelines

5. Overview

Speech/Language intervention includes the evaluation and treatment of the following disorders:

a. Receptive and Expressive Language: The comprehension and/or the expression of spoken or written language. Disorders in this domain may include one, a combination of or all of the components of a language system. The components include:

i. Phonology: The particular sound system of a language and the rules of the language that govern how sounds are put together;

ii. Morphology: The structure of words and the ways in which the rules of language govern how the words are put together to form new words;

iii. Syntax: The rules governing the order and combination of words in the formation of sentences and the relationship between the components in the sentence;

iv. Semantics: The individual word meanings and combing the word meanings to form the content of a sentence;

v. Pragmatics: The sociolinguistic components that govern the use of language in context.

b. Articulation: The production of speech sounds for a given age. Disorders in this domain are characterized by abnormal speech production of a given age.

c. Fluency: The flow of verbal expression. Disorders in this domain are characterized by impaired rate and rhythm and often accompanied by secondary struggling behaviors.

d. Voice: The production of voice. Disorders in this domain are characterized by abnormal initiation/duration, tonal quality, pitch, loudness, and/or resonance.

6. Guidelines for Speech/Language Interventions

Initial evaluation and subsequent six (6)-month re-assessment will determine the client's eligibility for speech/language intervention.

a. Receptive and Expressive Language: A significant delay in this area is defined as at least 1.5 standard deviations below the mean. Assessment in this area should include:

i. A comprehensive, standardized language measure that assesses both expressive and receptive language

ii. A secondary measure assessing the area of concern

iii. A discrepancy of at least one standard deviation between the overall expressive and receptive scores, or a discrepancy of one standard deviation between two or more areas described above, or a discrepancy of one standard deviation between language scores and a non-verbal cognitive measure

iv. Performance-based measure such as a parent/teacher questionnaire that corroborates with the data obtained on the standardized measure

v. Evidence of a passed hearing screening within the past six (6) months (authorization only)

b. Articulation Skills: A significant delay in this area is defined as at least three sounds that are developmentally delayed more than one year based on standardized norms, two sounds that are developmentally delayed more than two years, and one sound that is developmentally delayed more than three years. Assessment in this area should include:

i. Informal assessment of speech skills based on a conversation sample, to determine level of intelligibility

ii. Standardized assessment of articulation skills

iii. Performance-based measure such as a parent/teacher questionnaire that corroborates the data obtained on the standardized measure

iv. Oral motor assessment to determine the level of (if any) oral motor involvement

c. Fluency Skills: A significant delay in this area is determined by the use of a standardized assessment for fluency. An informal assessment of connected speech should first be done to determine the need for a formal assessment.

d. Voice Skills: Voice skills can be assessed informally by listening to connected speech and completing a voice profile questionnaire. A medical evaluation by an Ear/Nose/Throat (ENT) physician must be done to determine the need for voice therapy.

7. Authorization of Speech/Language Services

CMS / SFCCN will authorize services that meet the following criteria:

a. The evaluation criteria addressed in Section 2 (Guidelines for Speech/Language Interventions)

b. If the client is of school age, having documentation that the child is/is not receiving school-based therapy. If not, the reasons should be documented as to why not. If the child is receiving school based treatment, a copy of the child's Individualized Education Plan (IEP) should be included documenting the services provided.

c. Goals are individualized and specific to the client's needs and disability accounting for the severity, intensity, and longevity of the condition

d. Consistent with the best practice interventions (evidence-based practice) which includes the use of the most appropriate assessment tools, skilled therapeutic procedures, and cost-effective interventions

e. Reflecting parental/caregiver's involvement with the identification, implementation, and delivery of service

8. Plan of Care and Frequency of Therapies

A plan of care (treatment plan) will need to be submitted with the initial evaluation authorization request and subsequent six (6)-month re-assessment requests to describe:

a. Short and long term goals.

b. Treatment procedures that are evidence-based.

c. Frequency of therapy (#units per week; 1 unit = 15 minutes).

d. Goals for treatment should reflect the client's needs and severity of disability.

e. Goals incorporating carryover of skills to areas outside the therapy setting.

f. Projected outcome from therapy that will include functional level to be achieved by client to map discharge plan.

Guidelines for the utilization and delivery of therapy services will be as follows:

a. Intensive Therapy -Up to 12 units per week for new episode of acute condition for up to 6 months

b. Moderate Therapy -Up to 9 units a week for chronic condition or pre-existent condition for up to 6 months

c. Maintenance Therapy -Up to 6 units a week for developmental disability for up to 6 months

d. Consultative Therapy -Up to 6 units a month prior to dismissal for up to 3 months

Physical Therapy Authorization Guidelines

1. Physical therapy intervention includes evaluation and treatment of movement dysfunction resulting from impairment of the musculoskeletal, neuromuscular, cardiovascular/ pulmonary, and/or integumentary systems. Physical Therapists work to restore, maintain, and promote optimal independent function and to promote wellness and the optimal quality of life for the individual.

Physical Therapy intervention includes therapeutic exercise programs, manual therapy techniques, modality application, gait training, balance/coordination training, adaptive equipment assessment/instruction, orthotic assessment/instruction and sensory integration activities.

2. Guidelines for Physical Therapy Intervention
Physical Therapy is initiated with a prescription from a CMS consultant physician. Initial prescription allows for evaluation by the therapist with recommendations made by the therapist and submitted to the primary care physician for approval regarding need for treatment and plan of care. Evaluation will include completion of a standardized or a performance-based assessment tool describing motor/sensory involvement. Criteria for initial treatment is the documentation of atypical muscle control and/or sensory-motor deficits which limit functional skills of the child and the establishment of short and long term goals for the intervention. Standard treatment frequency /duration is twice weekly for thirty minutes (two units) at this time which is supported in current literature.

Therapy must include activities that require participation of a licensed therapist or therapist assistant. Therapy must consist of activities that meet at least one of the following criteria:

a. Will result in improved active participation of the child in normal daily routines or functional activities;

b. Will promote the acquisition of functional skills by the child;

c. Will assist in the prevention or decrease of musculoskeletal deformity;

d. Can be reinforced daily by the primary caregivers of the child in their daily routines;

e. Will provide pain relief.

3. Short term and long term therapy goals must be established that are consistent with the cognitive age and the medical condition of the child. Goals must be measurable with treatment notes supportive of activities that are goal directed during therapy.

4. Therapy will initially be approved at the standard treatment frequency/duration unless less intervention is requested in the initial evaluation. Increased duration of therapy visits (up to four units or 60 minutes each visit) may be approved in the following circumstances:

a. Intense post surgical intervention needed for prolonged duration or increased frequency to allow child to benefit fully from surgical procedure -example: following dorsal rhizotomy

b. Child has had a recent growth spurt that is associated with change in functional status of the child -example child with atypical lower extremity muscle tone who has experienced bone growth and associated increased tightness in involved musculature which results in decreased independence in functional skills

c. Child has change in functional status indicating need for increased intervention for specific period to assist in appropriate skill acquisition -example child has started to walk and additional intervention is needed to facilitate appropriate gait pattern

d. Child has severe involvement and therapist provides documentation that all appropriate and tolerated therapy activities are not able to be completed in standard treatment time.

5. Procedure for requesting extended frequency/duration of therapy treatment:

a. Therapist provides documentation that child has been consistently attending therapy and tolerating treatment sessions of at least 30 minutes twice weekly.

b. All requests must include relationship of extended treatment time to functional and measurable treatment goals

c. Documentation must include that the extended time is required to allow for specific handling techniques by medical professional such as stretching. Extended time should not be requested for practice activities which can be included in appropriate home program.

d. Extended treatment time is not approved for the convenience of family or provider

e. Specific gains from extended treatment times must be documented to justify continuation of extended time beyond three month period.

6. Length of Authorization for Physical Therapy Services:

Physical Therapy Services may be authorized from one to six months at the standard duration/frequency. Length of authorization is dependent on the diagnosis and the established goals of treatment. For example, a child with atypical muscle tone and global developmental delay may be anticipated to require authorization for six months while a child with an acute ankleinjurymayrequireservicesfor1to2monthsonly. Therapist is notified of the length of authorization following approval of the initial treatment plan. Therapist is required to submit a new treatment plan including current functional status of the child, progress on established treatment goals, and establishment of new goals which must be approved by the primary care physician to request continued authorization of services. Continued authorization for therapy services must be supported by a measurable response to treatment provided in the subsequent plan of care request. Consultative/maintenance therapy may be funded to allow therapist to work with primary caregiver regarding handling techniques and updating previously provided home programs as needed. Consultative therapy would be expected not to exceed six units per month.

ENROLLEE INFORMATION

CMS PROGRAM ELIGIBILITY

The Florida Medicaid program in Tallahassee determines eligibility for the Medicaid-CMS Title XIX Program.

PRIMARY CARE PROVIDER ASSIGNMENT

Every enrollee within CMSN-BROWARD must have an assigned Primary Care Provider (PCP) who will coordinate his/her medical care within the network. This provider/physician will handle the enrollee's primary care medical needs and will arrange for specialty and hospital care when necessary.

When enrolling with CMSN-BROWARD, each enrollee will either choose a Primary Care Provider or be assigned when he/she does not make an active choice. If a new enrollee has chosen or is assigned to a clinic setting or a group practice by name, the provider office needs to internally assign the enrollee a PCP. The assigned PCP should be the PCP of record whenever possible in order to facilitate continuity of care.

Families may select the same PCP for all family members enrolled in CMSN-BROWARD.

Primary Care Providers not willing to serve an enrollee or family should send a letter to the CMSN-BROWARD Enrollee Services detailing the circumstances and reason for this action. Enrollee Services in turn will transfer the enrollee to another PCP. If the Primary Care Provider had been assigned the enrollee in question and had rendered care prior to the submission of this letter, the Primary Care Provider is responsible to provide any necessary urgent or emergent care until such time that the enrollee has become established with another Primary Care Provider.

PCP TRANSFER REQUESTS

CMSN-BROWARD strives to maintain a positive relationship between the enrollee and his/her primary care provider. Enrollees may request a PCP change (transfer) by calling CMSN-BROWARD Enrollee Services (**866 209 5022**). The enrollee or the enrollee's legal guardian may initiate transfer requests. The enrollee will receive a new ID card from CMSN-BROWARD indicating the new PCP name. The PCP is expected to continue providing care until the effective date of the change.

Transfers resulting due to PCP Terminations

The following process occurs when a PCP terminates his/her contract with CMSN-BROWARD:

- Upon receipt of the PCP's termination notice, CMSN-BROWARD assigns the enrollee to a new provider within the practice, if available. If no other provider exist within the practice, CMSN-BROWARD assigns according to the zip code of the terminated provider.
- CMSN-BROWARD notifies the enrollee of the termination and the newly assigned PCP. If the enrollee would prefer a different PCP than chosen, he/she is asked to call CMSN-BROWARD to make the change.
- CMSN-BROWARD notifies AHCA, CMS Headquarters and the CMS Area Office in Broward of any and all changes in the provider network composition on a regular basis.

ENHANCED BENEFITS

Under Medicaid Reform the State of Florida has established a new program known as the Enhanced Benefit Account Program (EBA) to encourage healthy behaviors. Medicaid beneficiaries, including the special needs children enrolled in the CMS Title 19 program under reform in Broward are eligible to earn credits for engaging in approved healthy behaviors identified by the Agency. The Agency will credit a specific dollar amount to a Medicaid beneficiary/ CMSN-BROWARD enrollee's account for each healthy behavior documented, with a maximum accumulation of $125 per individual per year (September to September). The enrollee may then access the credit in the Enhanced Benefit Account to purchase approved health-related products and supplies not traditionally covered by Medicaid.

The list of approved healthy behaviors is a combination of services that are covered by CMSN-BROWARD and services in which the enrollees may participate outside of their health plan. Some of the approved healthy behaviors include:

- Keeping all primary care appointments
- Completing routine age-appropriate health screenings
- Compliance with the prescribed medication regimen
- Age-appropriate immunizations, including flu shots
- Participation in Disease Management Programs
- Completion of a weight management or smoking cessation program
- Participation in an Alcoholic/Narcotic Anonymous Program

CMSN-BROWARD reports healthy behavior data captured from claims/ utilization to the Agency on a monthly basis. Enrollees or provider/sponsor of healthy behavior can report healthy behaviors carried out outside of the health plan by completing the Enhanced Benefit Universal Form. CMSN-BROWARD will submit the completed Enhanced Benefit Universal Form to the Agency for the enrollee's account to be credited. The Agency maintains the account and sends a periodic statement of account to the enrollee. The statement provides current balance and account activity. The list of approved healthy behaviors and the Universal Form can be found on the internet at: **http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml**.

More information and guidance about this Florida Medicaid Reform program is available from the Enhanced Benefits Call Center at 866 421 8474.

ENROLLEE RIGHTS AND RESPONSIBILITIES

CMSN-BROWARD strives to foster enrollee satisfaction, respect, and availability of information through open communications. We, therefore, have written the following Enrollee Rights and Responsibilities.

- Each enrollee has the right to be treated with respect, courtesy, and dignity.
- Each enrollee has the right to have his/her privacy protected.
- Each enrollee who requests advice or assistance has the right to be assisted in a prompt, courteous and responsible manner.
- Each enrollee has the right to be provided with information about his or her diagnosis, treatment, and prognosis in terms that are understandable to him or her.
- Each enrollee has the right to have his or her medical record and all other information kept confidential unless permission to release such information has been given by the enrollee or the release is required by law.
- Each enrollee has the right to participate in decisions regarding his or her care.

- Each enrollee has the right to express grievances regarding the program or any violation of his/her rights.
- Each enrollee has the responsibility to try to be considerate and respectful of all treatment staff and to cooperate with the treatment staff. This includes following instructions from those rendering health care services and enrollees providing the staff with the information they need. If the enrollee has questions or disagrees with the treatment plan, he or she has the opportunity to discuss it with his or her doctor and the other treatment staff.
- Each enrollee has the responsibility to carry his/her ID card at all times and call his/her doctor or other health care providers when an appointment can not be kept.
- Each enrollee has the responsibility to call his/her doctor and CMSN-BROWARD Enrollee Services and the Florida Department of Children and Families (DCF) if he/she has a change of address or telephone number.
- Each enrollee has the right to be made aware of experimental treatment programs involving their care and the right to refuse to participate.
- Each enrollee has the responsibility for following the plan of treatment outlined by his or her physician or, if not possible, to request a new plan of treatment or alternately request assignment to another doctor.
- Each enrollee has the right to request a change of PCPs, specialist, dentist, or ancillary providers.

ENROLLEE GRIEVANCE and APPEAL PROCEDURES

"Grievance" means an enrollee is not satisfied with the provision of his/her health care or any of the administrative or office processes/staff. For example, an enrollee may not be satisfied with the availability, delivery or quality of care he/she received from a CMSN-BROWARD provider. Enrollees, their family member, a representative of their choice or a provider (whether participating or non-participating) acting on behalf of an enrollee and with the enrollee/family's written consent, may file a grievance about any issue causing dissatisfaction other than an action (service denial).

Enrollees may call Enrollee Services or put in writing a grievance regarding their dissatisfaction. The grievance must be filed within 1 year after the date of the occurrence that initiated the grievance. **Oral grievances must be followed by a written grievance.** When CMSN-BROWARD receives a grievance, the Grievance Coordinator may contact the enrollee to obtain information about the grievance.

A sample grievance form is attached for duplication by your office in the event it is requested by an enrollee/family. This form is also available from Enrollee Services. CMSN-BROWARD will give enrollees/families and/or a designated representative reasonable assistance in completing forms and other procedural steps, including but not limited to translation services and TTY/TDD interpretation services. At a minimum, the grievance must include: the enrollee name, address, telephone number and Medicaid ID#; a brief description of the grievance and the resolution being sought.

Grievances should be submitted in confidence to:

CMSN-BROWARD Grievance Coordinator
P.O. Box 460512
Fort Lauderdale, Fl 33346-0512

The Grievance Coordinator is available Monday through Friday, between 08:30am and 5:00pm and can be reached at 800 988 5640.

The Grievance Coordinator will acknowledge receipt of a grievance in writing within ten (10) business days of receipt. If the grievance is resolved in ten (10) days or less, the receipt of the grievance will include disposition information. The Grievance Coordinator will research and investigate the enrollee's grievances, collect information and interview persons relevant to the grievance in order to resolve the grievance within ninety (90) days from the date the grievance was received. CMSN-BROWARD may extend the grievance resolution time frame by up to fourteen (14) days if the enrollee/family requests an extension, or CMSN-BROWARD documents that there is a need for additional information and that delay is in the enrollee's best interest. If the extension is not requested by the enrollee, CMSN-BROWARD will give the enrollee/family written notice of the reason for the delay. CMSN-BROWARD will provide the enrollee with a written Notice of Grievance Disposition within ninety (90) calendar days of receipt of the grievance. The Notice will include the results and the date of the grievance resolution.

Grievances related to service authorization denials ("actions") will be processed and evaluated by the Appeals Committee for determination.

If the grievance is not resolved to the enrollee's satisfaction, the enrollee may request a Medicaid Fair Hearing.

No punitive action will be taken against a provider who files a grievance on behalf of the enrollee or supports an enrollee's grievance or appeal. The grievance procedure is the same for all enrollees

Appeals
Enrollees, their family member, a representative of their choice or a provider (whether participating or non-participating) acting on behalf of an enrollee and with the enrollee/family's written consent, may file an appeal in response to a "Notice of Action" (Service Denial letter) from CMSN-BROWARD or when CMSN-BROWARD fails to respond to an enrollee grievance within the established timelines.

The appeal must be filed within thirty (30) calendar days of receipt of CMSN-BROWARD's Notice of Action (Service Denial letter). The enrollee/family or designated representative may file an appeal orally or in writing. **If the filing is oral, the enrollee/family/ representative must also file a written, signed appeal within thirty (30) calendar days of the oral filing.** The Appeal Coordinator at CMSN-BROWARD may contact the enrollee to obtain information about the appeal.

CMSN-BROWARD will give enrollees/families reasonable assistance in completing forms and other procedural steps, including but not limited to translation services and TTY/TDD interpretation services. At a minimum, the appeal must include: the enrollee name, address, telephone number and Medicaid ID#; a brief description of the Action (service denial) being appealed and the resolution being sought.

Appeals should be submitted in confidence to:

CMSN-BROWARD Appeals Coordinator
P.O. Box 460512
Fort Lauderdale, FL 33346-0512

The Appeals Coordinator is available Monday through Friday, between 08:30am and 5:00pm and can be reached at 800 988 5640 or 954 767 5600.

The Appeals Coordinator will acknowledge receipt of a grievance in writing within ten (10) business days of receipt. The Appeal Committee will review the enrollee's appeal and will provide the enrollee/ family /representative with a reasonable opportunity to present evidence, in person or in writing, to further support the appeal. The Enrollee/family / representative will be afforded the opportunity to examine the enrollee's case file including all medical records. The Appeal Committee is comprised of CMSN-BROWARD health care professionals, experienced in medical and utilization management and with expertise in treating the enrollee's condition or disease. The participants in the Appeal Committee were not involved in previous level of review or decision-making.

CMSN-BROWARD strives to resolve each appeal within the State-established time frame not to exceed forty-five (45) calendar days from the date the initial appeal request (oral or written) was received.

CMSN-BROWARD may extend the appeal resolution time frame by up to fourteen (14) calendar days if the enrollee/family requests an extension, or CMSN-BROWARD documents that there is a need for additional information and that delay is in the enrollee's best interest. If the extension is not requested by the enrollee, CMSN-BROWARD will give the enrollee/family written notice of the reason for the delay. CMSN-BROWARD will provide written notice of the resolution of the appeal, including the results and date of the resolution within two (2) business days after the date of the resolution. For decisions not wholly in the enrollee's favor, The Notice of Appeal Resolution/Disposition will include information about: how to request a Medicaid Fair Hearing; how to request continuation of services during an appeal (including a Medicaid Fair Hearing) and; how to request a review by the Beneficiary Assistance Program. If the resolution is in favor of the enrollee, CMSN-BROWARD will authorize the provision of the disputed services promptly and as quickly as the enrollee's health condition requires.

When the enrollee/family/representative request, in writing, for the services to continue during the appeal process, CMSN-BROWARD will continue to provide the services in question to the enrollee

until: the enrollee withdraws the appeal; or the enrollee does not request a Medicaid Fair Hearing in a timely manner; or the Fair Hearing decision is adverse to the enrollee; or the service authorization expires or the enrollee meets the authorized service limits. If CMSN-BROWARD's action is upheld, the enrollee may be liable for the cost of any continuation of the disputed services.

Expedited (72-hour) Appeal
When an enrollee/family/ representative requests an appeal and CMSN-BROWARD determines or the provider indicates that taking the time for a standard appeal review could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, CMSN-BROWARD will expedite the appeal process. CMSN-BROWARD will review and resolve expedited appeals within seventy-two (72) hours after the expedited appeal request is received, whether the appeal was made orally or in writing. If CMSN-BROWARD denies the request for an expedited appeal, CMSN-BROWARD will provide immediate oral notification to the enrollee/family/ representative, followed by a written notice.

If the appeal is not resolved to the enrollee's satisfaction, the enrollee may request a Medicaid Fair Hearing.

No punitive action will be taken against a provider who files an appeal on behalf of the enrollee or supports an enrollee's grievance or appeal. The grievance procedure is the same for all enrollees

Medicaid Fair Hearing
If the grievance is not resolved to the enrollee's satisfaction, the enrollee may request a Medicaid Fair Hearing by contacting: The Office of Appeals Hearings
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, FL 32399-0700

Enrollees/families or their designated representative have the right to request a Medicaid Fair Hearing in addition to pursuing a resolution through CMSN-BROWARD's grievance/appeal process. Enrollees/families or their designated representative must request a Medicaid Fair Hearing within 90 calendar days of CMSN-BROWARD's Notice of Grievance or Appeal Disposition. The decision of the Medicaid Fair Hearing is final.

Enrollees have the right to request the continuation of services during a Medicaid Fair Hearing. However, if the CMSN-BROWARD action is upheld in a Medicaid Fair Hearing, the enrollee may be liable for the cost of any continued services.
If the enrollee chooses the Medicaid Fair Hearing, the enrollee is not eligible to appeal to the Beneficiary Assistance Program (BAP).

Beneficiary Assistance Program (BAP)
If the grievance or appeal is not resolved to the enrollee's satisfaction but the enrollee does not wish to request a Medicaid Fair Hearing, enrollees and/or their designated representative may request a review by the Florida Beneficiary Assistance Program (BAP). Before filing with the BAP, enrollees must exhaust CMSN-BROWARD's grievance/appeal process. The enrollee/family or the designated representative must submit the request for a review to BAP within 1 year after receipt of the final decision letter from CMSN-BROWARD. The decision of BAP is final.

Enrollees/ family or their designated representative can contact BAP at:
The Agency for Health Care Administration
Beneficiary Assistance Program
2727 Mahan Drive, Building 1, MS #26
Tallahassee, FL 32308
Telephone: 850 921 5458 or 888 419 3456

THE FOLLOWING SERVICES REQUIRE PRIOR AUTHORIZATION

Chemotherapy
CT Scan
Dental Services for Orthodontics, Appliances and Dentures
Dialysis
Durable Medical Equipment (DME) – ALL; Including, but not limited to:
a. Oxygen and related equipment/ services
b. Custom Wheelchair
c. Orthotics, Prosthetics and/or Braces
d. Insulin Pump
Elective Surgery (inpatient or outpatient)
Emergency Room Visits (Notification is required for payment processing only)
Growth Hormone
Hearing Aids
Home Health
Hyperbaric Oxygen Therapy
Inpatient Admissions
Invasive Diagnostic Procedures – ALL; Including, but not limited to:
a. Amniocenthesis
b. Angiograms, Angioplasty
c. Cardiac Catheterizations
d. Cystograms
e. Electrophysiological Studies (EPS)
f. Endoscopies
Magnetic Resonance Imaging (MRI)
Mental Health Inpatient Admissions
Nerve Conduction Studies / Electromyogram (EMG)
Nutritional Supplements
Observational Stays
Obstetrical Care (global)
Out-of-Network Services (OON), Including referrals and/or consultations
Oral Surgery (Medical)
PET Scan
Prescribed Pediatric Extended Care Services (PPEC) Day Care
Radiation Therapy
Sleep Apnea Studies
Specialist to Specialist Referrals
Stress Tests (Pharmacologic, exercise, Stress, Thallium, Cardiolyte, etc.)
Therapies – Occupational/ Physical/ Respiratory/ Speech
Transplants and related care
Video EEG

PRIOR AUTHORIZATION

All authorizations and or denial determinations will be based on member eligibility, benefits and medical necessity and will reflect appropriate application of nationally recognized practice guidelines to include but are not limited to InterQual, Medicaid guidelines, Medicare guidelines and national recognized professional associations as well as the Medicaid Coverage and Limitations Handbooks. If the request meets all the criteria, it will be assigned an authorization number.

Requests for services that do not meet criteria due to lack of information will be pended and returned to the requesting physician/provider's office for additional information. If requested information is not provided in a timely manner, (within 10 business days) the service request will be denied. If, after receiving the additional information, the request does not meet criteria for medical necessity or the requested service exceeds the Medicaid covered allowable, is not a covered benefit, or is a request for an out-of-network provider, the request will be forwarded to the appropriate sub-network Medical Director for review. Only sub-network Medical Directors are able to deny a request for authorization of services.

Authorization will be required for all items listed on the "prior authorization list" (see previous page). Payment for any services on the prior-authorization list which are rendered/performed without an authorization number will be denied for lack of authorization.

Emergency Room services and/or outpatient behavioral health services provided through participating Community Mental Health Centers do not require prior authorization.

Authorizations are valid for 60 days from the date issued unless otherwise specified.

PRIOR AUTHORIZATION FOR NEW CMSN-BROWARD ENROLLEES

Written documentation of prior authorization of ongoing services will be honored for thirty (30) calendar days after the effective date of enrollment in CMSN-BROWARD or until the PCP reviews the enrollee's treatment plan, whichever comes first. Services need to have been pre-arranged prior to enrollment. These services include:

a) Prior existing orders (including Home Health & Durable Medical Equipment)
b) Prior appointments and surgeries
c) Prescriptions (including prescriptions at non-participating pharmacies)

For patients hospitalized at the time of enrollment into the CMSN-BROWARD, CMSN-BROWARD will become responsible for days on or after the initial date of enrollment.

Time Frames for Authorization Determinations

CMSN-Broward strives to process provider requests for authorizations and assure a timely determination to accommodate the urgency of the situation.

Service authorizations requests will be processed during normal business hours (08:00am to 5:00pm, Monday through Friday) according to the following timeframes:

Service Requested:	CMSN-Broward Processing Time
Emergent	Within **four (4) hours** of receipt of request and necessary information.
Urgent	Within **one (1) business day** of receipt of the request and necessary information.
Routine	Within **two (2) business days** of receipt of the request and necessary information.

Authorization "Pending Status" will be processed within **five (5) business days** if all requested supporting documents are received.

Refer to the Authorization form included at the end of this Manual.

DENIAL OF SERVICE AUTHORIZATION

An "**Action**" is the result of an "adverse determination" by the Medical Management staff at CMSN-BROWARD to deny, reduce, suspend, terminate or otherwise limit the authorization of a requested service and/or the denial in whole or in part of payment for a service.

The enrollee/family and the ordering physician are notified in writing (Notice of Denial for Requested Services) when a service authorization request is denied. The enrollee or his/her representative wishing to appeal the "action" or adverse determination must submit their appeal in writing within thirty (30) calendar days from the date of the Notice of Action.

Appeals related to service authorization should be submitted in confidence to:

CMSN-BROWARD Appeals Coordinator
P.O. Box 460512
Fort Lauderdale, FL 33346-0512
Telephone: 1-800-988-5640 or 954-767-5600

The Appeal Coordinator is available Monday through Friday, between 08:30am and 5:00pm.

If the enrollee's health requires it, CMSN-BROWARD will seek to resolve the grievance more expeditiously, i.e. within seventy-two (72) hours, in accordance with the Florida Statute. Please refer to the Enrollee Grievance and Appeal Procedure section of this manual.

USE OF OUT-OF NETWORK PROVIDERS

In situations wherein (1) the requested service is not available within the established CMSN-BROWARD network or (2) the Primary Care Provider can not get an appointment with an in-network specialist for an enrollee within thirty (30) days, PCPs may request prior-authorization for the use of an out-of-network provider.

All out-of-network services require prior-authorization from the CMSN-BROWARD, including referrals to specialists (recommended by the Primary Care Provider). Providers must forward to the Utilization Management department a completed prior-authorization form and valid written documentation justifying the need for utilizing an out-of-network provider. The justification should include information regarding the services being unavailable in the existing CMSN-BROWARD network.

Please refer to the list of services that require prior authorization.

SERVICE INFORMATION

EMERGENCY SERVICES UTILIZATION PROCEDURES

Notification of Emergency Room Treatment

All notifications of Emergency Room services must be made to **866 209 5022**, except for behavioral health emergencies. Behavioral Health ER visits which must be reported to University of Miami Behavioral Health **(UMBH) at 800 294 8642**. Prior authorization is not required for emergency care (including behavioral health care).

Once the enrollee in the emergency room requires inpatient admission, this service requires a separate authorization number to be issued by CMSN-BROWARD at the time of notification and determination of medical necessity.

Scope of Emergency Room Services

Emergency services will be provided to all enrollees in accordance with State and federal laws. CMSN-BROWARD will monitor emergency room utilization. Emergency services and care are defined as: medical screening, examination and evaluation by a physician or to the extent permitted by applicable

laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition is determined to exist, the care, treatment, or surgery by a physician for a covered which is necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital. Once the Utilization Management Department is notified of the Emergency Room visit the PCP will be notified in writing in order to initiate appropriate follow up care.

Enrollee's should not be sent to the Emergency Room for the following conditions:

- Routine follow-up care
- Follow-up for suture or staple removal
- Non-emergent care during normal business hours

OUTPATIENT HOSPITAL SERVICES

Referrals for outpatient hospital services will be processed by the Utilization Management Department. Please refer to the section of this manual under Utilization Management entitled, "Referral/Authorization Process."

Outpatient hospital services are defined as those preventative, diagnostic, therapeutic or palliative services provided at a licensed hospital on an outpatient basis under the direction of a physician or dentist. These outpatient hospital services include emergency room, dressings, splints, oxygen and physician ordered supplies necessary for the clinical treatment of a specific diagnosis or treatment as specified in the Medicaid Hospital Coverage and Limitations Handbook.

There are some outpatient Medicaid service limitations for outpatient hospital services such as surgery, obstetrical procedures, dialysis services, the fitting of burn garments and the related garments.

CMSN-BROWARD providers may not bill the enrollee for outpatient charges for office visits and related procedures. Primary care services provided in hospital-owned outpatient clinics and satellite facilities cannot be billed on the UB04 claim form. Physician services must be billed using the CMS 1500 claim form and the claims must be submitted to CMSN-BROWARD unless otherwise specified.

SECOND OPINION

CMS enrollees have the right to seek a second opinion from a qualified health care professional who is a Medicaid Provider in the CMSN-BROWARD's network or non-network provider (the latter when an in-network provider is not available), at no cost to the enrollee. Regardless of the second opinion rendered, the enrollee will be required to utilize an in-network provider for on-going care including procedures or surgery.

HOME HEALTH SERVICES

Home Health (HH) Services, whether at the time of discharge from a hospital or from the community, **MUST BE ORDERED BY THE ATTENDING PHYSICIAN**. The request for authorization should be forwarded to the Utilization Management Department either by the vendor, provider or CMS care coordinator. The CMSN-BROWARD care coordinator will refer the enrollee to a network provider.

A Plan of Care (POC) should be submitted with the authorization request/Referral Form. The Plan of Care/orders from the attending physician shall include the following:

- Enrollee's acute or chronic medical condition that causes the enrollee to need home health care.
- Medical necessity for the service(s) to be provided at home (Enrollees must be deemed homebound).

- The specific Home Health service(s) needed.
- The frequency and duration of the service(s); and
- The minimum skill level of staff who can provide the service(s)

Follow-up with the enrollee during the course of treatment under Home Health will be conducted by the CMS care coordinator. The CMS care coordinator may also notify the PCP/ordering provider of the enrollee's progress with treatment. This action does not replace the PCP-HH Agency communication, it enhances collaboration between all parties.

Note that the PLAN OF CARE FOR HOME HEALTH CARE WILL EXPIRE EVERY 62 DAYS and the ordering provider must request a new Plan of Care from the Home Health Agency. FOR THOSE CHILDREN RECEIVING ONGOING HOME CARE SERVICES, THE ATTENDING PHYSICIAN MUST EVALUATE THE PATIENT AT A MINIMUM OF EVERY 6 MONTHS. Plans of Care will not be approved without documentation of physician evaluation of the recipient at a minimum of every 180 days. If the PCP/provider does not certify a continued need, the enrollee and the Home Health Agency will be notified that CMSN-BROWARD will not be authorizing continued services and will not be responsible for payment if the service is rendered past the date of the notification or disenrollment of the enrollee. Because CMSN-BROWARD has contracted home health care providers, enrollees may not directly seek services or call the companies. The ordering provider needs to coordinate the care with the home health company and the enrollee. We are bound by the State's contracted External Quality Review Organization (EQRO) and by Medicaid therefore, your cooperation is requested to avoid technical denials.

DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES

Durable Medical Equipment (DME) must be ordered by the provider and the referral request must be submitted to the Utilization Management Department. A physician's order should be submitted along with the Authorization Request/Referral Form. The CMS care coordinator may contact the enrollee during the course of treatment.

The CMSN-BROWARD's Utilization Management Department may also contact the provider to discuss the enrollee's progress with the requested Plan of Care and may recommend alternatives, if indicated. Note that a physician's order for DME will expire every ten (10) months for rental items and every six (6) months for supplies. These will have to be re-certified. The re-certification will either be initiated by the CMS care coordinator, or by the ancillary provider. For those children receiving on-going DME requiring renewals, the attending physician must evaluate the patient at a minimum of every six months (6) months. Recertification will not be approved without documentation of physician evaluation of the enrollee at a minimum of every 180 days. If the PCP/provider does not certify a continued need, the enrollee and the DME provider will be notified that CMSN-BROWARD will not be authorizing continued services, and will not be responsible for payment if the service is rendered past the date of the notification or disenrollment of the enrollee. CMSN-BROWARD has specific contracted vendors for DME/medical supplies. We are bound by the state's contracted External Quality Review Organization (EQRO) and Medicaid therefore your cooperation is requested in order that technical denials can be avoided.

LABORATORY SERVICES

Laboratory services will be utilized at one of CMSN-BROWARD's Network Hospital Facilities or by any laboratory that provides services for Medicaid recipients.

OUT OF SERVICE AREA MEDICAL NEEDS

Procedures/services that are requested out of the service area must be prior-authorized and deemed medically necessary by CMSN-BROWARD's Utilization Management Department. At the time of the referral to the Utilization Management Department, the supporting documentation must accompany the

referral request. Emergency room requests will be reviewed retrospectively from claims data by CMSN-BROWARD's Medical Director.

All out-of-service area requests for service will be reviewed and the CMSN-BROWARD Medical Director will make determinations on delivery of care. Out-of-service area authorizations will be determined by the availability of services offered within the network and medical necessity.

CMS AFFILIATED SPECIALTY PROGRAMS

Participating providers are encouraged to utilize CMS Affiliated Specialty Programs for referrals, when appropriate. The following are some of the CMS Affiliated Specialty Programs that apply to children of all ages. For additional information regarding these centers, contact the local CMS office in Broward at **954 713 3100**.

CHILDREN'S CARDIAC PROGRAM

A network of cardiac services has been approved by Children's Medical Services (CMS). Clinic services are available at CMS area office locations for children and young adults under the age of 21 years who meet the CMS financial and clinical eligibility criteria. Cardiac catheterization and surgical facilities have also been approved to provide families with access to tertiary centers for diagnostic or interventional catheterizations as well as surgical services. These services are coordinated with each enrollee's PCP.

The CMS Cardiac Program strives to lessen children's illnesses from their cardiac condition by aiding in assessment prior to their involvement in physical activities and involving parents and children in developing an appropriate life style. In addition, the program is developing a system to provide rapid transmission of diagnostic studies for evaluation and to offer area-wide educational programs.

CMS CRANIOFACIAL/CLEFT LIP & CLEFT PALATE PROGRAM

Through Children's Medical Services a network of cleft palate clinics and craniofacial centers has been approved for infants and children with cleft lip, cleft palate, and craniofacial anomalies who are sponsored by CMS. All infants and children with craniofacial anomalies may be referred to a CMS cleft palate clinic or craniofacial center by their parent, guardian or PCP.

When an infant is born with a cleft lip, cleft palate or craniofacial anomalies, the birth hospital staff and the parents receive individualized feeding instruction for the baby and educational materials (brochures, videos, etc.) while in the hospital. In addition they are informed about the services that are provided by CMS. The parents are offered an initial hearing screening for their newborn at the nearest infant hearing impairment center. For all infants and children with cleft lip, cleft palate, or other craniofacial anomalies the program staff will arrange an initial, comprehensive evaluation by a CMS approved cleft palate clinical team at no cost to the family. The most complex children may be referred for further evaluation by a CMS approved craniofacial center team when requested by the Cleft Palate Team Director or CMS Medical Director.

LIVER TRANSPLANT PROGRAM

The State of Florida Pediatric Liver Transplant Program is designed to provide an integrated infrastructure to support pediatric liver transplantation in the state of Florida. The statewide program is composed of Pediatric Transplant teams and the program goals include decreasing costs and improving clinical outcomes for children with liver transplants. The program emphasizes coordinated case management and education of the patient, family and primary care provider.

PEDIATRIC HEMATOLOGY/ONCOLOGY PROGRAM

The Pediatric Hematology/Oncology Program is a regionalized program that was initiated in 1988 when testing for blood disorders, such as sickle cell disease, was added to the Newborn Screening Program. The CMS Hematology/Oncology Centers around the State provide care for infants, children, and youth diagnosed with cancer or blood disorders. When a Newborn Screening Program test for blood disorders is not normal, the Centers also provide follow-up testing to confirm a diagnosis.

REGIONAL PERINATAL INTENSIVE CARE CENTERS (RPICC)

The major goal of the Regional Perinatal Intensive Care Centers Program is to deliver optimal medical care to women with high-risk pregnancies and to sick/preterm newborns. Studies have indicated that maternal, fetal, and neonatal mortality rates can be reduced through early identification and early and continuous provision of specialized health care to pregnant women and newborns at high risk for disease, death, or disability.

Regional Perinatal Intensive Care Centers have been designated throughout the state in order to improve the delivery of perinatal care services through:

- the concentration of high cost specialized health care and clinical expertise in designated hospitals in the state,
- the provision of community- based consultative prenatal services, and
- the provision of specific education for health care professionals involved with perinatal care.

MEDICAID HANDBOOKS AND OTHER RESOURCES

The Florida Medicaid program has many handbooks available to providers to assist in delineating coverage benefits and limitations which CMSN-BROWARD providers are responsible for following. These guidelines may be accessed online at: http://mymedicaid-florida.com or hard copies may be purchased through AHCA. In the CMS Program, all Medicaid handbooks and other benefits and limitations are applicable.

CMSN-BROWARD QUALITY MANAGEMENT PROGRAM

The mission of CMSN-BROWARD is to improve the quality of care to CMS enrollees within a managed care system of delivery, to provide a high standard of health care and education, to improve the health status of the community, and to earn patient and customer satisfaction. We believe that this can best be accomplished with each enrollee having a Primary Care Provider as this fosters continuity of care. To accomplish this, a comprehensive Quality Improvement Program (QIP) has been developed. The Agency for Health Care Administration (AHCA) will evaluate CMSN-BROWARD's performance through contractually-established indicators.

The medical services your practice provides determine which of the following quality indicators will be assessed. The specific indicators include at least:

- Access to services after (PCP) office hours.
- Mortality of enrollees
- Health status indicator of enrollees
    1. Immunizations - Percentage of enrollees at age 2 who have completed the basic immunizations.
    2. Well child health care utilization (Preventive Care)
    3. Other health care utilization
- Family request for PCP reassignment
- Enrollee or family perspectives of care, including compliance and grievances.
- Personnel/Provider satisfaction including turn over rates, physician disenrollment, and satisfaction with payment and authorization system.
- Medical record documentation

Enrollee Availability/Accessibility to Services:

CMSN-BROWARD providers are required to meet the following access to care standards and provide services within the following time frames:

- Emergency Medical Care - available 24 hours a day/7 days a week
- Urgent Care - within one day
- Routine Sick Care - within one week
- Well Care - within one month

After Hours Availability/ Call Coverage

- Access must be 24 hours a day/7 days a week
- After hours access must be with someone who is licensed to render a clinical decision
- After hours access does not include an answering machine unless it results in a prompt callback by a licensed clinician.

The scope of the Quality Monitoring Program incorporates:

- The generation of utilization reports for services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies, durable medical equipment companies, and pharmacies
- Facility audits and medical record reviews to monitor services provided by PCPs and high volume specialists
- Monitoring practice guidelines through medical record reviews and utilization reports

- The monitoring of high volume/high risk services based on review of demographic and epidemiological distribution of enrollees
- Services reflecting acute and chronic care
- Continuity and coordination of care
- Over and under utilization of medical resources
- Enrollee and provider satisfaction surveys
- Complaint and grievance monitoring and analysis
- Compliance with practice guidelines including preventive health guidelines

Credentialing and Re-credentialing Processes

CMSN-BROWARD will recredential providers minimally at three year intervals. In addition to being in good standing with the Agency for Health Care Administration (AHCA), the CMSN-BROWARD credentialing process will review applicants for recredentialing using their achievement of quality indicators, compliance with medical record standards, conformity to access and site maintenance standards, grievance and complaint trending, peer review outcomes and utilization management.

Medical Records Documentation

The following medical record standards apply to each enrollee's record and will be used as a guide for the periodic on-site record reviews:

- Must contain identifying information on the enrollee, including name, enrollee Medicaid identification number, date of birth, sex, and legal guardianship
- Must be legible and maintained in detail as to permit an external reviewer to follow the progression of care
- Contain a summary of significant surgical procedures, medical history, past and current diagnosis or problems, allergies, current medications and untoward reactions to drugs
- All entries must be dated and signed by the appropriate care giver
- Must indicate the chief complaint or purpose of the visit; the objective findings of practitioner; diagnosis or medical impression
- Must indicate studies ordered, for example: lab, x-ray, EKG, and referral reports. Test results and findings of diagnostic studies need to be reviewed by the physician and added to the record in a timely manner
- Must indicate therapies administered and prescribed
- Must include the name and profession of practitioner rendering services, for example: M.D., D.O., O.D., including signature or initials of practitioner
- Must include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up, and outcome of services
- Must contain a complete immunization history
- Must contain information on smoking, alcohol/substance abuse (14 years and older)
- Must contain summaries of all emergency services and care and hospital discharges (such as Discharge Summary) with appropriate medically indicated follow-up
- Documentation of referral services and result of referral and/or consultation reports
- Documentation of all services provided, including but not necessarily limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Reflect the primary language spoken by the enrollee and any translation needs of the enrollee.
- Identify enrollees needing communication assistance in the delivery of health care services
- For enrollees 18 years and older: Documentation that the enrollee was provided written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the enrollee has executed advance directives. The execution or waiver of advance directives does not constitute a condition of treatment.

- Behavioral health records must include – for each service provided, clear identification as to:
  - The physician or other service provider
  - The date of service
  - The units of service provided AND
  - The type of service provided

Annually, CMSN-BROWARD will conduct a review of medical record documentation practices of contracted PCPs. Enrollee record reviews will be conducted by trained, qualified personnel who will use the standards outlined above and will assess compliance with confidentiality and security of enrollee records. A minimum of five (5) records will be reviewed for each provider. The reviews will be scheduled in advance with your office staff and, whenever possible record audits for other functions, such as Pediatric Preventive Care, will be conducted concurrently to minimize unnecessary disruptions to your practice.

PCPs are required to meet a minimum passing score of 90% of the overall record review. The review score and findings as well as opportunities for improvement will be discussed with the physician or his designee, at the time of the audit. PCPs who fail to meet the scoring threshold for record reviews will be educated on the medical record requirements and performance will be re-evaluated at regular intervals.

The data from medical record reviews are included in the quality improvement and credentialing (re-credentialing) activities.

Pediatric Preventive Care

CMSN-BROWARD is committed to encourage preventive healthcare through the application of the periodicity schedule for children/adolescents immunizations and the pediatric health screening schedule.

CMSN-BROWARD will audit the medical record at the provider office for compliance with the following:

1. Evidence /documentation of appropriate Child Health Check-Up (CHCUP) requirements evidenced by:
   a. A complete history and (unclothed) physical exam, that reviews all 8 body systems, at least annually
   b. Periodic vision screenings (at birth to 3 years, 10 years and 16 years)
   c. Periodic hearing screenings
   d. Complete exam of the external genitalia – appropriate for age group
   e. Documentation of body system review, head circumference (up to age 2), vital signs, height and weight
2. Appropriate laboratory testing evidenced by:
   a. PKU, Galactosemia, Thyroid and Sickle Cell screens done at 48hours (hospital nursery)
   b. Hematocrit and Hemoglobin levels at 1 year, 5 years and when clinically indicated
   c. Urinalysis at 9 months and between 3-6 years
   d. Cholesterol screening - when clinically indicated (i.e.: high risk families)
3. Current, complete immunizations evidenced by:
   a. Temperature recorded prior to administration of immunization
   b. Diptheria, Tetanus and Pertussis (DTP) or Tetramune at 2, 6 and 15-18 months
   c. Hemophilus Influenza (Hib) at 2, 4, 6, 12-15 months or PedvaxHIB or Comvax at 2 and 4 months
   d. Inactivated Polio (IPV) at 2, 4, 6-18 months and 4-6 years
   e. Measles, Mumps and Rubella (MMR) at 12-15 months and 4-6 years
   f. Hepatitis B (HepB) at 1-4mo and 6-18 months
   g. Tetanus-Diptheria (Td) at 11-12 years (5 years since last dose) and booster every 10 years

h. Tuberculosis screening (PPD) prior to entering school and/or for high risk
i. Varicella (VZV) at 12-18 months unless documented history of Chicken Pox;
j. Pneumovax / Pneumococcal Conjugate at 2, 4 and 6 months and booster at 12-15 months

4. Lead Screening evidenced by:
    a. Capillary or venous blood testing at 9-12 months and 24 months for high risk children
    b. Lead poisoning prevention counseling during each well child visit
5. Dental Assessment evidenced by:
    a. Regular brushing and flossing and preventive dental care
    b. Advice about tooth decay caused by excessive use of baby bottle
    c. Referral to dental professional
6. Substance abuse assessment – appropriate for age group – evidenced by:
    a. Documentation of family history of alcoholism, DUI, smoking and/ or substance abuse
    b. Counseling about sharing un-sterilized needles and syringes
    c. Advice to pregnant women about potential risk to fetus
    d. Consent prior to drug testing
    e. Referral to tobacco cessation / primary substance abuse prevention program
7. Assessment for child abuse, neglect and/or domestic violence, evidenced by:
    a. Education and counseling to parents/ guardians
    b. Advice on "SAFE" risk factors: poor social support, low socio-economic status, single-parent families, unexplained or unwanted pregnancies
    c. Assessment for physical signs: burns, bruises, unexplained injuries and/or other signs of sexual abuse
    d. Assessment of emancipated minors for frequency and severity of past / current physical abuse and/or forced sexual activity
    e. Appropriate and timely response to suspected child abuse, neglect and/or domestic violence
8. Assessment of sexual development and behavior, evidenced by:
    a. Assessment of menarche/ menstrual cycle (female)
    b. PAP Smear at 21 years and older, or when sexually active
    c. Counseling about safe sexual practices, contraceptives, STD, rape awareness
    d. VDRL/RPR (venereal disease research laboratory/ rapid plasma reagin), HIV (Human Immunodeficiency Virus) and STD (sexually transmitted disease)testing – as indicated
    e. Advice about self-breast exam (female) and self-testicular exam (male) for adolescents
9. Age-group appropriate education to parent/ guardian and patient
    a. Diet-related
    b. Exercise regimen
    c. Injury prevention (poison control, effect of passive smoking, school violence, water safety, etc.)

10. Children should receive health check-ups at:
    - 2-4 days
    - 2-4 weeks
    - 2, 4, 6, 9, 12, 15, 18, and 24 months
    - Once a year from ages 3 to 21 years (except ages 7 and 9)

A Well Child Check-up includes:

- Hearing screening;
- Vision screening;
- Dental screening;
- Health and developmental history;

- Immunization (when needed); and
- Treatment as needed.

Quality and Performance Improvement

It is the intention and purpose of CMSN-BROWARD to continually improve the quality of care and service provided to CMS enrollees. The methodology to achieve this goal is based on establishing standards and performance goals for the delivery of care and services, measuring performance and taking appropriate interventions to improve the outcomes. Clinical indicators such as HEDIS, CAHPS Survey, Generic Outcome Screen Indicators (GOSI), medical record documentation standards and preventive health initiatives are nationally recognized indicators of performance.

HEDIS (Health Employer Data & Information Sets) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS also includes a standardized survey of consumers' experiences – the CAHPS Survey - that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS measurements are collected annually and the project is sponsored, supported and maintained by NCQA (the National Commission for Quality Assurance).

The CAHPS Survey (Consumer Assessment of Health Plan Satisfaction) uses a standardized instrument to evaluate consumer satisfaction with the health plan and the network of providers on an annual basis.

GOSI will be utilized in the Peer Review Process to review potential quality of care issues, risk management issues and to investigate any potential "sentinel events" or occurrences where there was potential harm to the enrollee or other unexpected outcomes including mortality and morbidity.

CMSN-BROWARD conducts periodic audits of medical records at the provider office to evaluate compliance with documentation standards as well as appropriateness of clinical care (diagnosis and corresponding treatment) and use of appropriate, nationally-recommended preventive health guidelines.

In addition, CMSN-BROWARD evaluates its performance and the performance of it participating providers through complaint and grievance monitoring and analysis as well as participation in medical management and utilization processes.

All of the CMSN-BROWARD's PCPs, including Family Physicians, Internists, General Practitioners, Pediatricians, Obstetrician/Gynecologists are subject to ongoing performance evaluation and monitoring.

Peer Review

Provider performance with quality of care and services is monitored through the Peer Review Committee (PRC) and process. Peer review responsibility resides with a committee or committees of licensed physicians who are part of the CMSN-BROWARD physician network. The PRC's responsibilities include:

1. Review of credentialing and re-credentialing applications
2. Conformance with the CMSN-BROWARD standards for access and availability and medical record maintenance
3. Preventive care guideline compliance
4. Validated enrollee complaints
5. Review of Generic Outcome Screening Indicators (GOSI)
6. Review outcomes that reflect unexpected or less than ideal results through GOSI.

Substandard Provider Performance

CMSN-BROWARD's intentions to address substandard performance will increase in severity ranging from the tracking and trending of provider practices from the passive accumulation of data, suspension of additional assignment of enrollees, to the transfer of enrollees to another physician provider and/or the termination of privileges under the CMS contract. Whenever an action must be taken immediately in the best interest of patient care, a provider's contract can be summarily suspended.

A provider whose (1) Florida license, (2) DEA number, and (3) Medicaid/Medipass Provider numbers are revoked or suspended must **IMMEDIATELY** notify CMSN-BROWARD. The revocation or suspension of any of the above licenses or numbers will lead to an automatic suspension of the provider's Service Agreement with CMSN-BROWARD. The provider may re-apply to become a CMSN-BROWARD provider, if and when, the revoked or suspended license or number is reinstated.
There is a process in place at CMSN-BROWARD that offers the provider an opportunity to appeal the determination. The provider-appeal process may be initiated by the provider contacting the Medical Director or Executive Director of CMSN-BROWARD in writing at 1525 NW 167th Street, Suite 103, Miami, FL 33169. The final determination on the provider appeal will reside within the provider-appeal system already in place at CMSN-BROWARD. CMSN-BROWARD will be responsible for reporting adverse peer review determinations to the National Practitioner's Data Bank that may have resulted in the loss of status or participation in the CMSN-BROWARD network either on a temporary or on a permanent basis.

Regulatory Oversight

Children's Medical Services (CMS) - Florida's Department of Health (DOH) and the Agency for Health Care Administration (AHCA) will be providing oversight for this program and will be closely monitoring the quality indicators defined in this section as well as compliance with all requirements of the Florida Medicaid program. In accordance with the requirements of your Service Agreement with CMSN-BROWARD, providers are expected to fully cooperate with all audits, surveys and desk reviews relating to the CMS population served by CMSN-BROWARD.

1. Enrollee Grievance form model (optional use by enrollees and families)
2. Authorization form (Subnetwork-specific)
3. List of Services Requiring Prior Authorizations
4. Medical Record Documentation Review Tool
5. Generic Outcome Screen Indicators (GOSI)
6. Useful Telephone Numbers

Upon request, CMSN-BROWARD will provide an enrollee/provider with this grievance form within 3 business days of the request. Enrollees/providers have a maximum of 1year from the date of the occurrence to file a grievance.

CHILDREN'S MEDICAL SERVICES NETWORK

GRIEVANCE FORM

ENROLLEE'S NAME:	**DATE:**
ADDRESS:	**TELEPHONE:**
PROVIDER:	**Enrollee I.D#:**
ADDRESS	**Provider TELEPHONE:**
Children's Medical Services Network (CMSN-): ☐ **Miami-Dade (Monroe)** ☐ **Broward -South** ☐ **Broward-North**	
DESCRIPTION OF GRIEVANCE: (Use back of this page, if needed)	
HOW WOULD YOU LIKE TO SEE THIS MATTER RESOLVED?	
FOR HEALTH PLAN: Grievance Resolved to Enrollee Satisfaction: ☐ Yes ☐ No Date:	
To Grievance Committee: (Date)	
BAP Info provided: ☐ Yes ☐ No (Not applic. Grievance resolved)	

Confidential - Please forward immediately to the Grievance Coordinator @ CMSN- Broward P.O. Box 460512, Fort Lauderdale, FL 33346

NORTH BROWARD HOSPITAL DISTRICT

Pre-Certification / Authorization Form *(for CMSN-BROWARD North)*

Fax to: 954 767 5649 Request Priority (circle one): **Stat** **Urgent** **Routine**

Today's Date: LOB (circle one): PPUC PSN CMS Other: _____

Member Information:

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone #: _____

Member Address: _____

Provider Information:

Office Contact Name: _____ Phone #: _____

Service Requested by (circle one): PCP Specialist

PCP Name: _____ Phone # _____ Fax # _____

Specialist Name: _____ Phone # _____ Fax # _____

Specialty: _____ Address: _____

Signature of Requesting Physician: _____ Date: _____

Clinical Information:

Diagnosis (ICD-9): _____

Clinical Summary / Findings: _____

_____

_____

Please attach relevant office records, test results, attempted treatments, second opinions, consults to support this request.

Requested Services (circle one):

1. Inpatient Outpatient Office
2. Consultation Only Follow-Up
3. Number of visits requested: 1 2

Indicate which service is requested: _____

Name of Facility: _____ Estimated Length of Stay: _____

For Best Choice Plus Internal Use Only

Approved Date: _____ Authorization #: _____ (use within 60 days)

Pended Date: _____ Reason: _____

Denied Date: _____ Reason: _____

Statement to Provider: This authorization is for medically necessary services only. Payment is contingent on services being authorized, services being a covered benefit, coordination of benefits and enrollee eligibility at the time of service. Additionally, it is important that a report of the service or treatment rendered to this enrollee be forwarded to the PCP.

SERVICES REQUIRING PRIOR AUTHORIZATION

Chemotherapy
CT Scan
Dental Services for Orthodontics and Appliances
Dialysis
Durable Medical Equipment (DME) – ALL; Including but not limited to:
a. Oxygen and related equipment/ services
b. Custom Wheelchair
c. Orthotics, Prosthetics and/or Braces
d. Insulin Pump
Elective Surgery (inpatient or outpatient)
Emergency Room Visits (Notification is required for payment processing only)
Growth Hormone
Hearing Aids
Home Health
Hyperbaric Oxygen Therapy
Inpatient Admissions
Invasive Diagnostic Procedures – ALL; Including but not limited to:
a. Amniocenthesis
b. Angiograms, Angioplasty
c. Cardiac Catheterizations
d. Cystograms
e. Electrophysiological Studies (EPS)
f. Endoscopies
Magnetic Resonance Imaging (MRI)
Nerve Conduction Studies / Electromyogram (EMG)
Mental Health Inpatient Admission
Nutritional Supplements
Observational Stays
Obstetrical Care (global)
Out-of-Network Services (OON) – including referrals and /or consultations
Oral Surgery (Medical)
PET Scan
Prescribed Pediatric Extended Care Services (PPEC) Day Care
Sleep Apnea Studies
Radiation Therapy
Specialist to Specialist Referrals
Stress Tests (Pharmacologic, Exercise, Stress, Thallium, Cardiolyte, etc.)
Therapies – Occupational/ Physical/ Respiratory/ Speech
Transplants and related care
Video EEG

GENERIC OUTCOME SCREENING INDICATORS (GOSI)

(This information is confidential and proprietary in nature and for internal Quality Improvement purposes only.)

CRITERIA

1. **Unexpected admissions or complication of admission for adverse results of outpatient management. The following selected admission diagnoses could possibly be indicative of inadequate or inappropriate care in the ambulatory setting, such as:**
   - A. Diabetic Coma or Acidosis
   - B. Ruptured Appendix
   - C. Hypertensive Crisis
   - D. Bleeding or Perforation
   - E. Gangrene
   - F. Carcinoma of the Breast; Advanced (Primary)
   - G. Carcinoma of the Cervix
   - H. Drug Overdose/Toxicity/Sub-Therapeutic Drug Level(s)
   - I. Fracture Management; Adverse results of
   - J. Cellulitis/ Osteomyelitis
   - K. Bowel/Intestinal Obstruction
   - L. Bleeding Secondary to Anticoagulation
   - M. Electrolyte Imbalance
   - N. Septicemia
   - O. Pulmonary Emboli
   - P. Eclampsia/Pre-eclampsia
   - Q. Fetal Deaths
   - R. Thrombosis; Deep venous, on Oral Contraceptives
   - S. CVA/TIA
   - T. Dehydration
   - U. Carcinoma of the Colon; Advanced Primary
   - V. Carcinoma of the Lung-Advanced Primary
   - W. Airway Disorders including Croup, Asthma and Bronchitis
   - X. Gastroenteritis with Dehydration
   - Y. Nosocomial Infection (including MRSA)
   - Z. Postpartum Complication
   - AA. Drug Reaction

2. **Unexpected Readmissions within 30 days of Discharge, such as:**
   - A. Post-op complication
   - B. Re-admission of the same problem/diagnosis

3. **Unplanned transfer from a low level of care (general care) to a higher level of care (intensive care)**

4. **Hospital Incurred Incidents, such as:**
   - A. Fall- with or without fracture, dislocation, laceration requiring suturing, concussion, loss of consciousness
   - B. Anesthesia complication(s)
   - C. Major preventative allergic reaction to drug
   - D. Transfusion error or life- threatening transfusion complication
   - E. Hospital acquired decubitus ulcer
   - F. Adverse drug reaction or complication from medication error:
   - G. Any hospital occurrence which could potentially require an incident report
   - H. Consent problems.

5. **Unplanned removal, injury and/or repair of an organ (or part of an organ) during an operative procedure or surgery performed on the wrong patient.**

CRITERIA
6. **An unplanned return for additional operative procedures, or an unplanned open surgery after closed or laparoscopic surgery.**
7. **Myocardial Infarction, such as:** A. During or within 48 hours of a surgical procedure on this admission. B. Death more than 24 hours after admission. C. Hemorrhagic complications prior to discharge or transfer for patients receiving thrombolytic therapy.
8. **Concurrent Intervention, such as:** A. Delay in seeing patient B. Inappropriate care, failure in ordering or requesting a consultation C. Inappropriate care relating to diagnosis D. Delay in surgical intervention
9. **Organ failure not present on admission (kidney, heart, lung, brain etc.)**
10. **Burn not present on admission, cast (pressure), chemical, electrical, or thermal**
11. **Drug/Antibiotic utilization which is unjustified, excessive, inaccurate, results in patient injury, or is otherwise at variance with professional staff criterion.**
12. **Unexpected abnormal laboratory, x-ray, other test results or physical findings not addressed by physician**
13. **Complication of Vascular Access Lines** A. Pneumothorax responding to rest or needle aspiration B. Pneumothorax requiring closed chest drainage or thoracotomy C. Pneumothorax requiring surgical intervention D. Complication of Hickman ports E. Dialysis ports removed/new ports F. Iatrogenic pneumothorax
14. **Obstetrical (OB) complications such as:** A. Pyemic embolism B. Pulmonary embolism C. Air embolism/Amniotic embolism D. Obstetrical shock E. Bleeding F. Abortions 1. Cervical lacerations during first trimester abortion 2. Pelvic infections following first trimester abortion G. Postpartum Infection H. Unexpected low Apgar score
15. **Delay or Missed Diagnosis**
16. **Access to care, such as:** A. Failure to obtain accepting physician(s) B. Long wait to get an appointment C. Failure in ordering or requesting a consultation D. Inadequate access to PCP E. Excessive/multiple emergency room usage F. Adverse effect of inadequate access to PCP

CRITERIA
17. **Quality of Care—Adverse or unexpected outcomes**
18. Performance of Medically Unnecessary Procedures
19. **Sentinel events, such as:** a) The death of a patient b) Brain or spinal damage to a patient c) The performance of a surgical procedure on the wrong patient, or d) The performance of a wrong –site surgical procedure e) The performance of a wrong surgical procedure f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition g) The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process h) The performance of procedures to remove unplanned foreign objects remaining from surgical procedure i) Infant abduction or discharge to the wrong family j) Suicide or attempted suicide of patient k) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibility l) Patient escape/elopement m) Sexual battery on a patient

-All GOSI will be evaluated as per Subnetwork and/or hospital system protocol, including reporting of Code 15 events to AHCA and review of JCAHO sentinel events as related to accreditation requirements.

MEDICAL RECORD REVIEW TOOL

CMSN Subnetwork: ☐ BROWARD-South ☐ BROWARD-North ☐ DADE

Practice Name: Date of Review:

Provider Name: Prov Medicaid #:

Provider Address/Location:
Address City Zip

Provider Specialty: # Records Reviewed:

#	Review Element / Medical Record Requirement	Chart #1	Chart 2	Chart 3	Chart 4	Chart 5
		Indicate: Y, N or N/A[1]				
1.	**Is there an individual record per member?**					
2.	**Does the record contain the necessary enrollee identification: a) Enrollee's Name, b) Enrollee ID / Medicaid ID#, c) DOB, d) Gender**					
3.	For under-aged enrollees: Does the record indicate the enrollee's parent(s) or legal guardian, as indicated?					
4.	**Are each page of the medical record identified (enrollee's name, ID#)?**					
5.	**Is there a name and telephone number for emergency contact?**					
6.	**Is the primary language spoken, translation needs and/or communication assistance noted?**					
7.	**Is the record legible and sufficiently detailed?**					
8.	**Are all entries dated and signed?**					
9.	**Is there a summary of significant surgical procedures, past and current diagnoses or problems (i.e.: Problem List)?**					
10.	**Are allergies and/or untoward reactions to drugs prominently displayed?**					
11.	**Is there a list of current medications?**					
	Is there documentation of:					
12.	**a) the chief complaint or purpose of the visit?**					
13.	**b) are the problems identified from previous visits addressed?**					
14.	**c) objective/clinical findings?**					
15.	**d) diagnoses or impression of the provider for each visit?**					
16.*	**e) A treatment plan, consistent with the diagnosis?**					
17	Is there documentation of the studies ordered (e.g. laboratory, x-ray, EKG) as well as the report/result of the study?					
18	**Are all therapies administered and treatments prescribed documented?**					

19	**Do all entries must include the name and professional designation of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider?**					
20	**Do all entries include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcomes of services?**					
21	**Is there evidence/ documentation of whether there was follow-up and/or the outcome(s) of the services?**					
22	**Is there a complete immunization history?**					
23	For enrollees 14 and older: Is there documentation relating to the enrollee's use of tobacco products and alcohol/substance abuse?					
24	Are summaries of emergency service/visits and care and hospital discharges with appropriate medically- indicated follow-up included in the record?					
25	Are referral services and result of referral and/or consultation reports documented?					
26.*	Is there documentation of appropriate Informed Consent?					
27.*	Is there documentation of medically appropriate health education?					
28.	*Title XIX* – Are all service provided documented, including but not limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases?					
29.	*Title XIX – For enrollees 18 years old and older:* Is there documentation that Advance Directive was discussed / offered?					
30.	**Is the record maintained in a secured area, accessible only to authorized personnel?**					
31.	**Is there evidence of reasonable efforts on the part of the provider/staff to maintain confidentiality of the medical record?**					

** Represents review elements in addition to CMS/AHCA requirements . These additional review elements conform to good professional practice & documentation standards.*

*Review Elements in **BOLD** MUST be present in every record, for every enrollee encounter (i.e. Cannot be "N/A" or not applicable).*

[1] N/A Responses apply only for the review elements NOT bolded.

Scoring: Total "Y" = _____ Total "N" = _____ Total [Y + N] = _____

Overall score in % = Total "Y" divided by Total [Y=N] x 100 SCORE: _____

Minimum required passing score: 90%

The findings of the MRR were discussed with the Provider/ Representative Yes No

A copy of the completed MRR TOOL was left with the Provider/Representative Yes No

Reviewer Signature: _____ Date: _____

Provider /Representative: _____ Date: _____
Print Name

Provider/ Representative Signature: _____ Title: _____

SOUTH FLORIDA Community Care Network
Memorial Healthcare System - North Broward Hospital District - Public Health Trust

FOOD SUPPLEMENTS – PRIOR AUTHORIZATION

LOB: [ ] PSN [ ] CMS-T19 [ ] CMS-T21

Date_____ Time_____ Recipient's Medicaid ID#_____

Date of Birth_____/_____/_____ Recipient's Full Name_____

Is Recipient Medicare eligible? _____ WIC Eligible (for nutritional)? _____ Institutionalized?_____

Prescriber Full Name _____ Prescriber License # (ME,OS,RN)_____

Prescriber Telephone#_____ Prescriber Fax#_____

Pharmacy Name_____ Pharmacy Medicaid Provider #_____

Pharmacy Phone #_____ Pharmacy Fax #_____

Food Supplement Requested:_____ Quantity: (Units/Ounces)_____

Dosage and frequency of dosing:_____ % of Total Caloric Intake product will provide:_____

Length of Therapy on Prescription:_____ Oral or Tube Administration :_____

Diagnosis:_____ Diagnosis ICD-9 Code:_____

Patient Height and Weight (required):_____Date measured:_____

Reason for use of any food supplement other than basic liquid 1-2 Kcal/ml supplement:_____

Consultation with a Registered Dietician? Yes_____ No_____ Date_____ Name:_____

****** REQUIRED PHYSICIAN CERTIFICATION STATEMENT ****:**

" I hereby certify that, the food supplement ordered for this patient is medically necessary."

Physician Name: _____ _____ **Signature:**_____**Date:**_____

A copy of the prescription must accompany this form. Attach lab results and other documentation as necessary. The provider must retain copies of all documentation for five (5) years.

Children under 5 year's old, pregnant and postpartum women **must** register with the federal program for women, infants, and children (WIC). If WIC cannot supply all of the recipient's needs, Medicaid may authorize additional products.

Is this Child registered with WIC? Yes____ No_____ Date:_____ If yes, what does WIC provide ?_____

Fax to: Memorial Integrated Health
Fax #: (954) 602-2863 or 2808
Phone #: (954) 893-1002

OR

Broward Health
Fax# (954) 767-5649
Phone # (954) 767-5600

INTERNAL USE ONLY:
Date:_____
Notified:_____

Approved:_____ Start Date:_____ Expiration Date:_____

Denied:_____
Reason:_____

USEFUL TELEPHONE NUMBERS

Broward County Health Department	954 467-4756
Family Planning	954 467 4938
HIV/AIDS	954 467 4807
Immunizations	954 467 4943
Teen Health	954 467 4790
CMS Area Office – Broward:	954 713 3100
CMSN-BROWARD:	
Enrollee Services	866 209 5022
Provider Services	954 767 5500 or 800 988 5640
Complaints	954 767 5600 or 800 988 5640
Claims Inquiries	954 767 5500 or 800 988 5640
Appeals	954 767 5600 or 800 988 5640
Utilization Management/Authorizations	954 767 5600 or 800 988 5640 Fax: 954 767 5649
Department of Children and Families District 10 – Broward Broward Regional Services 201 W. Broward Blvd, Suite 406 Ft Lauderdale, FL 33311	954 467 4298
Domestic Violence Hotline	800 500 1119
Florida KidCare	888 540 5437
Non-Emergency Transportation - LogistiCare	866 250 7455 (Reservations) or 866 251 9161 (Ride Assistance)
Medicaid (Area 10 – Broward) 1400 W Commercial Blvd., Suite 110 Ft. Lauderdale, FL 33309	954 202 3200 or 866 875 9131
Medicaid Beneficiary Assistance Program	888 419 3456
Medicaid Fiscal Agent (EDS)	800 289 7799
Medicaid Fraud and Abuse Hotline	888 419 3456

UMBH (Behavioral Health)	800 294 8642

DEFINITIONS AND ACRONYMS

Abuse - Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid 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 recipient practices that result in unnecessary cost to the Medicaid program.

Action – The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure of the Plan to act within ninety (90) days from the date the Plan receives a Grievance, or forty-five (45) days from the date the Plan receives an Appeal. For a resident in a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise his or right to obtain services outside the network.

Advance Directives - 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.

Agency - State of Florida, Agency for Health Care Administration.

AHCA - Agency for Health Care Administration.

Appeal - A request for review of an Action, pursuant to 42 CFR 438.400(b).
Beneficiary Assistance Program - An external grievance program available to Medicaid Reform recipients that will allow an additional avenue to resolve a grievance or an appeal.

Choice Counselor - The State's contracted or designated entity that performs functions related to outreach, education, counseling, enrollment and disenrollment of potential enrollee into a health plan.

CMS - Children's Medical Services. A program of the Florida Department of Health.

CMSN-BROWARD - Children's Medical Services Network – Broward.

Complaint - In accordance with section 641.47, F.S., any expression of dissatisfaction by an enrollee, including dissatisfaction with the administration of claims practices, or provision of services. A complaint is part of the informal steps of a Grievance procedure.

DCF - The Florida Department of Children and Families. The State agency responsible to overseeing programs that identify and protect abuse and neglected children and attempt to prevent domestic violence.

DOH - Florida Department of Health

Emergency Medical Services and Care - Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists. If an Emergency Condition exists, Emergency services and care includes the care and treatment that is necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Expedited Appeal Process - The process by which the Appeal of an Action is accelerated because the standard time-frame for resolution of the Appeal could seriously jeopardize the enrollee's life, health or ability to obtain, maintain or regain maximum function.

Federally Qualified Health Center - An entity that is receiving a grant under section 330 of the Public Health Service Act and the Social Security Act. These centers provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and mental health services.

Fiscal Agent - Any corporation, or other legal entity, that enters into a contract with the Agency to receive, process and adjudicate claims under the Medicaid program.

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

Grievance - An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

ICS - Integrated Care System. A comprehensive contracted program of services for children with special health care needs.

Medicaid Reform - The program resulting from Chapter 409.91211, F.S..

Medical Necessity or Medically Necessary - Services that include medical or allied care, goods or services furnished or ordered to:

1. 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 be experimental or 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.
2. Medically Necessary or Medical Necessity for those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
3. The fact that a provider has prescribed recommended or approved medical or allied goods or services does not in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a covered service/benefit.

QIP - The Quality Improvement Program. The process of assuring the delivery of health care is appropriate, timely, accessible, available and Medically Necessary.

QRO - Quality Review Organization. An organization that meets the competence and independence requirements set forth in federal regulations 42 CFR 438.354, and performs external quality reviews, other related activities as set forth in federal regulations or both.

RPICC - Regional Perinatal Intensive Care Center. A unit approved by DOH, 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.

SFCCN - South Florida Community Care Network, the collaborative partnership of three (3) governmental health systems in Broward and Dade Counties: Public Health Trust (PHT) in Miami-Dade, Memorial Healthcare System (MHS) in South Broward and North Broward Hospital District (NBHD) in North Broward to provide comprehensive health care in a Provider Service Network (PSN) model.

SSI - Supplemental Security Income

TANF - Temporary Assistance for Needy Families

Title XIX - A title of the federal Social Security Act relating to Medicaid and applicable to children under 21 years old.

Urgent Care or Urgent Medical Needs - 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, etc.) or do substantially restrict an enrollee's activity (e.g., infectious illness, flu, respiratory ailments, etc.)