FLORIDA
COMMUNITY CARE

PROVIDER HANDBOOK

Effective September 2018

Welcome Letter

A Message from our CEO

Welcome aboard! Florida Community Care (FCC), a Provider Service Network (PSN), would like to thank you for choosing to partner with our plan. As a new Florida Statewide Medicaid Managed Care Program (SMMC) health plan authorized to provide health care services to Florida's Medicaid population, we look forward to collaborating with our providers, to offer quality health care and long-term care services.

FCC has established as a guiding principle, a commitment to partnerships with community-based organizations, providers and caregivers, to enhance our ability to deliver value-based managed care services, specifically aimed at fostering independence and improving health outcomes. Our mission is to provide high-quality solutions across the health care continuum to aged, blind and disabled individuals in the least restrictive environment; always maintaining focus on our effort to ensure enrollees have access to the covered services they need. Good communication is a key component to our mutual success in the fulfillment of our mission for the enrollee.

We are proud to have you as one of our provider choice options and look forward to working closely with you in this endeavor. Our team will always do everything possible to continue to earn your trust and goodwill.

This Provider Handbook serves as a reference guide. It is one of our multiple methods of communication and is part of the provider training mandated in the Statewide Medicaid Managed Care (SMMC) program.

Please review the Provider Handbook carefully. Should you have any questions or concerns, they can be addressed by calling the appropriate contacts as listed on the "Reaching Florida Community Care and our Partners" Table available at www.fcchealthplan.com.

Thank you again.

Nestor J. Plana

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Tips for using this Handbook

This is your Florida Community Care Provider Handbook. The Handbook is for long-term care service providers, physicians, hospitals, ancillary providers, facilities, and other acute care providers participating in the Florida Community Care Network.

We understand that managing an enrollee's health is often complex and can be administratively taxing. This Handbook was developed to assist in understanding requirements and serve as a resource for answering questions you may have about our networks, products, programs, coding and claims filing guidelines; among other things.

This Handbook is not intended to be a complete statement of polices or procedures for providers. Other policies and procedures, not included in this Handbook, may be posted on our website or published in special publications, including but not limited to, letters, bulletins, and/or newsletters.

Any section of this Handbook may be updated at any time. Florida Community Care will notify providers of updates in a variety of ways, depending upon the nature of the update, including mailings, publications, our provider newsletter, or posting to our website. Please refer to our website at www.fcchealthplan.com to access the most up to date information.

In the event of any inconsistency between information contained in this Handbook and the agreement(s) between you or your facility and Florida Community Care (Agreement), the terms of such Agreement shall govern. Also, please note that at various times when dealing with Florida Community Care, you may be provided information concerning an enrollee's status, eligibility for benefits, and/or level of benefits. Florida Community Care will only issue payment in accordance with the applicable benefit plan in the individual's actual eligibility as determined by such benefit plan. Further, the presentation of a Florida Community Care identification card, neither creates nor serves as definitive verification of any enrollee's status or eligibility to receive benefits. Please check eligibility prior to rendering services.

To improve efficiency, all providers are strongly encouraged to conduct business with us electronically. It is important to note that we reserve the right to change the location of a website, a benefit plan name, branding or the customer identification card identifier. The plan will send notification to providers. When these changes occur and apply to you, we will communicate such changes to you.

Reaching Florida Community Care and our Partners

If you need to contact us, please navigate to www.fcchealthplan.com to access contact information for all current Florida Community Care departments, partners and vendors, as well as other helpful resources.

Please note that contact information is subject to change. The plan will make every attempt to maintain accurate information in this Handbook, but the most current information will always be available on the website at www.fcchealthplan.com.

Florida Medicaid and the SMMC Program

Medicaid Program

Florida Medicaid is the state and federal partnership that provides health coverage for selected categories of people in Florida with low incomes. Its purpose is to improve the health of people who might otherwise go without medical care for themselves and their children. The state and Federal Government share the cost of the Medicaid program. Medicaid services in Florida are administered by the Agency for Health Care Administration (AHCA).

Medicaid eligibility in Florida is determined either by the Department of Children and Families (DCF) or the Social Security Administration (for SSI recipients).

DCF determines Medicaid eligibility for:

- Parents and caretakers relatives of children
- Children
- Pregnant women
- Former foster care Individuals
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving Supplemental Security Income (SSI)

Statewide Medicaid Managed Care (SMMC) Program

The Agency for Health Care Administration (AHCA) is responsible for administering the Statewide Medicaid Managed Care (SMMC) program. Most Florida Medicaid recipients are enrolled in the SMMC Program. The SMMC program has three components: the Long-term Care (LTC) program, the Managed Medical Assistance (MMA) Standard or Specialty program, and the Dental Program. Members who qualify for both the LTC and MMA programs will receive their benefits from the same health plan. As a Long-term Care Plus Plan, Florida Community Care offers both LTC and MMA benefits to our members.

Additional information about the SMMC program can be found at this link:

http://www.ahca.myflorida.com/Medicaid/statewide_mc/

AHCA or its agent(s) are responsible for eligibility determinations and enrollment into Medicaid managed care plans, including outreach activities, education activities and enrollee disenrollment. Florida Community Care will accept enrollees in the order in which they enrolled without restriction and regardless of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services.

Florida Community Care

The Statewide Medicaid Managed Care (SMMC) has authorized Florida Community Care to provide Florida LTC Plus services to Medicaid enrollees who qualify and become enrolled in the LTC program and the MMA program. The health plan will work with different providers to offer quality health care

services and long-term care services to ensure enrollees have access to covered services as needed. Florida Community Care's goals are to:

- Keep enrollees safely in the community in the least restrictive environment possible
- Preserve the enrollee's dignity and promote the enrollee's autonomy
- Improve enrollees' functional independence and quality of life
- Ensure quality of care by utilizing best practice guidelines with providers
- Prevent hospitalization, emergency room visits, and nursing facility placement
- Coordinate palliative care and hospice
- Support caregivers with disease management tools, appropriate respite care and education about specials needs, such as Dementia/Alzheimer's

Role of Case Managers

All services will be managed through a case manager. Case management services help enrollees access needed medical, social, and educational services. Each Florida Community Care enrollee will be assigned to a case manager that will coordinate and ensure delivery of medical care and long-term care services available under the program.

Florida Community Care case managers will develop individual plans of care that address identified problems, needs, and conditions. Case Managers also coordinate the delivery of covered services, issue authorizations for covered service, and coordinate and integrate acute and long- term care services.

Florida Community Care case managers will collaborate with the enrollee's physicians and other providers to arrange for needed care and provide frequent communication with enrollees to evaluate and discuss needed care. Case managers always promote independent living and quality of life.

Case managers will routinely assess enrollee needs and perform interventions as necessary. Such interventions may be performed by:

- Face-to-face home visits with enrollee and family/caregiver(s)
- Telephonic follow-up with enrollee and family/caregiver(s)
- Provision of educational materials
- Communication with service providers, including physicians

Case managers will provide authorization for long-term care services when the services meet the following conditions:

- They are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- They are reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;
- They are furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;
- And, one of the following:
  - They enable the enrollee to maintain or regain functional capacity; or

- They enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

Enrollee Identification Cards

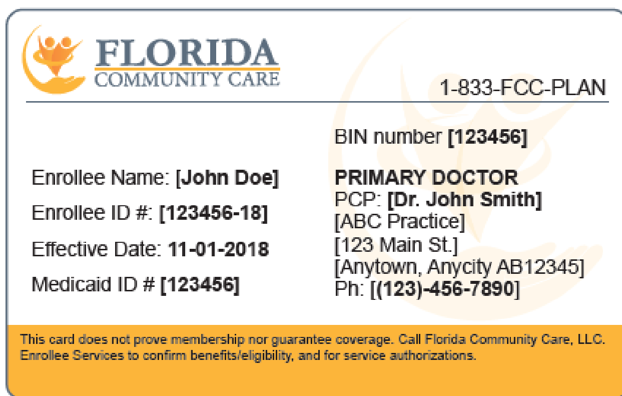
Florida Community Care enrollees receive a health care ID card from FCC which is designed to help you access our automated phone or online systems to verify benefits, eligibility and claim status. Each health care ID card includes a unique identifier.

The presentation of our ID cards in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract which the Provider has executed.

Should the enrollee lose or misplace the ID card, a new one can be obtained by contacting FCC Enrollee Services at 1-833-FCC-PLAN, Option 1 or requesting same online at: www.fcchealthplan.com

Sample Plan ID Cards

Medicaid Enrollee ID Card Sample:



IMPORTANT CONTACT INFORMATION FOR ENROLLEES

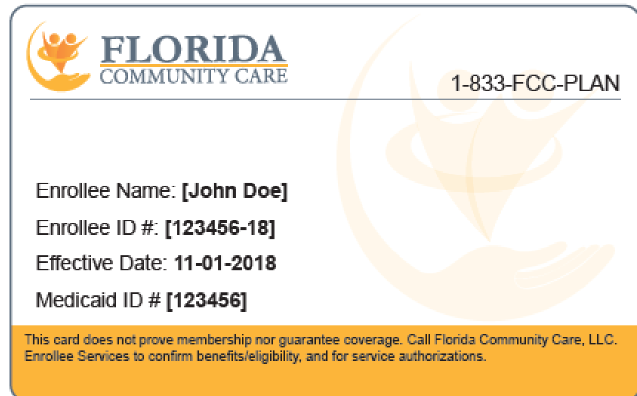
www.fcchealthplan.com

Florida Community Care, LLC.
PO Box 261060
Miami, FL 33126

For Enrollee Services: 1-833-322-7526 (TDD/TTY 711), Option 1
For Eligibility Verification & Claims: 1-833-322-7526, Option 2
For Other Provider Questions: 1-833-322-7526, Option 2
For Billing Information for Non-Participating Providers: 1-833-322-7526, Option 2
Pharmacy Benefits: [1-800-000-0000]
Behavioral Health Benefits: 1-888-308-9758

Submit Claims to: Florida Community Care, LLC. Attn: Claim Dept.
P.O. Box 211322 Eagan, MN 55121
Payee ID # [12345]

Medicare Enrollee ID Card Sample:



IMPORTANT CONTACT INFORMATION FOR ENROLLEES

www.fcchealthplan.com

Florida Community Care, LLC.
PO Box 261060
Miami, FL 33126

For Enrollee Services and Care Assistance: 1-833-322-7526 (TDD/TTY 711), Option 1
For Eligibility Verification & Claims: 1-833-322-7526, Option 2
For Other Provider Questions: 1-833-322-7526, Option 2
For Billing Information for Non-Participating Providers: 1-833-322-7526, Option 2

Submit Claims to: Florida Community Care, LLC. Attn: Claim Dept.
P.O. Box 211322 Eagan, MN 55121
Payee ID # [12345]

Behavioral Health

Florida Community Care manages behavioral health services for Florida Community Care enrollees and our care managers will work collaboratively with providers to meet our enrollees' mental health and substance abuse disorder needs. Enrollees should call 1-833-FCC-PLAN for assistance.

Access2Care (Non-emergency Transportation)

Florida Community Care has contracted with Access2Care to provide non-emergency transportation (NET) to Florida Community Care enrollees. FCC case managers will coordinate transportation for our enrollees to and from all medical appointments or LTC program services. Enrollees should call 1-833- FCC-PLAN for assistance.

CVS (Pharmacy)

Florida Community Care has contracted with CVS as its Pharmacy Benefit Management (PBM). CVS will administer pharmacy benefits and provides related products and services to Florida Community Care enrollees. Enrollees should contact their local pharmacy or call 1-833-FCC-PLAN for assistance.

HearUSA (Hearing)

Florida Community Care has contracted with HearUSA to provide hearing services to our enrollees. HearUSA will administer hearing benefits and provides related products and services to Florida Community Care enrollees. Enrollees should call 1-833-FCC-PLAN for assistance.

iCare (Vision)

Florida Community Care has contracted with iCare Health Solutions to provide optometric and ophthalmic services to our enrollees. iCare Health Solutions will administer vision benefits and provides related products and services to Florida Community Care enrollees. Enrollees should call 1-833-FCC-PLAN for assistance.

Working with Florida Community Care Tools and Resources

Doing business with us is easier and faster than ever when you take advantage of the wealth of information and resources available to you online. Stay up-to-date on our latest products and programs and process changes by simply accessing bulletins, newsletters and other valuable resources and tools available on our website.

Provider Newsletter & Communication Tools

When visiting our Provider Portal, take a moment to sign up for the Florida Community Care provider notice system which provides many benefits including:

- Receiving important and timely information by email at your desktop
- Tracking, reading and saving information electronically and retrieving it easily when needed
- The ability to forward important information to others in the office

Provider Handbook

This Provider Handbook shall serve as a source of information regarding Florida Community Care covered services, procedures, statutes, regulations, telephone access and special requirements. A copy of the Handbook is available online at our website: www.fcchealthplan.com. A hard copy can be requested via phone at no additional cost to you by contacting our Provider Relations Department at: 1- 833-FCC-PLAN, Option 2

Provider Portal

The FCC Secure Web Portal is a web-based platform that allows FCC to communicate enrollee information directly with providers. Providers and their supporting staff can access several functions within this platform including:

- Enrollee Eligibility Status
- Authorization Status
- Claims Status
- Claim Inquiry Request

To access this information, providers must first register for the portal by navigating to www.fcchealthplan.com and clicking on the Provider Portal link. Please see below for more information.

Provider Portal Registration

Username: User accessing the Portal is to create a username
First Name: First name of the user that would be accessing the Portal
Last Name: Last name of the user that would be accessing the Portal
Email: Email of user that is accessing the Portal

Provider/Facility information is to be entered on the appropriate screens within the sign up process

First Name*

Last Name*

Department*

Contact Name*

Title*

Address Line 1

Address Line 2

City

State

-- Select --

Zip

TIN*

NPI

Previous Next Cancel

You must enter your TIN and NPI during registration. If you need to add additional TINs or NPIs, you may do so by clicking on the UPDATE MY INFORMATION link after you complete your initial registration.

Eligibility Inquiry

Verifying Enrollee Eligibility: To determine whether an enrollee is eligible for benefits, click on the Eligibility link. Here, you may search for enrollee eligibility, which may be downloaded to your computer.

Eligibility Results

Claim Status Inquiry

To check on the status of claims, users will click on the Claims link. From here users may search for enrollee's claim by entering their Enrollee ID or Claim Number. To Narrow your search, enter start and end dates of service. Once users locate the claim, they may select to view the claim details (date claim received, payee name, payment address, bulk check amount and more).

Home | Eligibility | Claims | Prior Authorizations

> Claims

Welcome, Test test

Search Options:
Claim Number, [redacted] ID, Medicaid ID
Any of the below and Date

For Check Number searches, be sure the number entered is 8 digits long. You may need to add leading zeros to make entry 8 digits.

If searching by [redacted] ID, please make sure your entry ID is 11 digits. You may need to add leading zeros.

Status Legend:

P=Processed
S, C=In Process
R=Reversed
D=Claim Deleted
A=Adjustment in Process
V=Voided

Claim Number(s): | [redacted] ID: | Begin Date: 6/6/2015 | End Date: 6/6/2018 | Check Number

Search

Quick Links
- Update My Information
- Frequently Asked Questions
- Universal Billing Code Amendment
- NAMI Update

External Links
- Enrollment Request for ERA (Electronic Remittance Advice)

Supported browsers
This portal supports the latest 2 versions of the following major browsers:
Older browsers are supported on a limited basis and the portal may display differently.

Claim Status Result

To submit a claim inquiry, follow the “click here to ask a question about this claim” at the top of Claim Detail Screen. Each inquiry will be reviewed and responded to by the Provider Services Claims Department within the required timeframes.

Click here to ask a question about this claim

Claim Number(s): | ID: | Begin Date: 6/6/2015 | End Date: 6/6/2018 | Check Number

Search

Claim

Date Received: | Member: | ID:
Provider Name: | Provider ID: | Account Number:
Date Paid: | Check Number: | Status:
Reversal Code: | Reversal Description:

Claim Details

Date(s) Of Service	Procedure Code(s)	1st Modifier	POS	NOS	Charged	Allowed	Copayment	Total Amount Paid	Total Paid By Other Ins	EOB Code	Message Code
05/16 - 05/31/2018	0120		31	16	$4,891.20						14
05/16 - 05/31/2018	0022		31	16							14
	Interest							$0.00			
Total					$4,891.20	$0.00	$0.00	$0.00	$0.00		

Check Summary

Date Paid	Check Number	Stock	Payee ID	Payee Name	Bulk Amount

Code Descriptions

14 - DENIED - PLEASE SEE DETAILED MESSAGE CODE

Claim for

Back to Search Results | Print View

Claims Adjustment / Inquiry

Claim Inquiry | Attachments (0)

Claim Inquiry

In order to effectively review your inquiry please complete this form. To attach a document, please click on the 'Attachments' tab above.
Select 'browse' to search for and attach your document. Please note that your attachment will be secure.

Fields marked with an * are required.

CLAIM INFORMATION

* Claim Number:
* Provider ID Number:
* Provider Name:
* CIN/Member ID Number:
* Patient Name:
* Date of Service (MM/DD/YYYY): 5/16/2018

Procedure Code(s) In Question:

* Billed Amount: $4,891.20
* Request For: Select One

Please note: If attachment is needed, please click on the Attachment tab at the top of this form and upload your document(s)

If Other selected above, please explain:

Statement of Remittance Date:

* Summary of Action Requested:
* Requestor's Name:
* Telephone Number:
* Requestor's E-mail Address:
* Verify E-mail Address:

By clicking 'Submit' this serves as a valid signature

Your changes will not be processed until the 'Submit' button is selected

Submit

To check authorization status, users click on the Prior Authorization link to search for enrollee's authorizations by entering their Enrollee ID or Authorization Number. Searches may be narrowed by entering start and end dates.

Figure 1 Authorization Inquiry

Home | Eligibility | Claims | Prior Authorizations

> Authorization Status Inquiries

Welcome, Test test

Quick Links
- Update My Information
- Frequently Asked Questions
- Universal Billing Code Amendment
- NAMI Update

External Links
- Enrollment Request for ERA (Electronic Remittance Advice)

Authorization Number(s):

ID:

Date of Birth:

Begin Date: 6/6/2015

End Date: 9/5/2018

Search

If searching by ID, please make sure your entry is ID 11 digits. You may need to add leading zeros.

Search Options:
Auth Number or ID only
Any of the above and DOB
Any of the above and Date

Authorization Results

Authorization

Print View

Patient Information

Authorization Number:	Member Name:	GuildNet ID:	Member DOB:

Authorization Details

Servicing Provider:	Authorization Status:	Authorization Status Reason:	
	APPROVED	APPROVAL PAR	
Procedure Code:	**Procedure Code Description:**		
8E0ZX	ISOLATION		
Diagnosis:	**Diagnosis Description:**		
F0390	UNS DEMENT W/O BEHAVIORAL DIST		
Place of Service:	**Certified LOS:**	**Start Date:**	**End Date:**
OTHER LOCATION	183	06/01/2018	

Disclaimer

This site is intended as a reference tool for providers. Any and all services/procedures are subject to benefit coverage, limitation and exclusions as per applicable plan coverage guidelines. Be advised that prior authorization is not a guarantee of claims payment.

Provider and Community Training

Training is delivered through a variety of methods such as:

- Webinars and Town Hall Training Sessions
- One-on-one with individual providers
- Written materials – Provider Handbook

Training materials are available through the health plan website at www.fcchealthplan.com.

Florida Community Care's Provider Network

Physicians and providers are selected to participate in our network based on an assessment and determination of the network's needs. To be considered for participation, you must be an enrolled (either Limited Enrolled or Fully Enrolled) provider with Florida Medicaid. If you are not currently enrolled with Florida Medicaid, complete the enrollment process prior to moving forward with your request to participate in the FCC Network.

From time to time, our provider network may be closed or partially open for recruitment of providers in specific service areas, provider types or services. It is important to confirm the provider network status prior to initiating your request to join our network. Please contact Provider Services at 1-833-FCC-PLAN, Option 2 for more information.

Credentialing with Florida Community Care

The verification of credentials is an integral part of our network process. It helps ensure our enrollees have access to quality care and it is also required to meet both state and federal guidelines.

We currently use Council for Affordable Quality Healthcare (CAQH) as our preferred method of application data; please ensure that your current CAQH is complete and accurate, and that attestations are complete and current. This will help facilitate the credentialing verification process. Credentialing staff perform the credentialing verification process and will access your CAQH application or contact you regarding completion of a credentialing application if you do not use CAQH. We highly recommend that you consider using CAQH as it will make the credentialing and recredentialing process much easier.

Long-term Care service providers, Ancillary Facility/Supplier Businesses and Ambulatory Service Centers (ASC) are not required to use CAQH. These providers must complete and submit a credentialing application.

If additional application information is needed from a provider, you may be contacted by credentialing staff on behalf of Florida Community Care. Be sure to comply with any response for additional credentialing information timely to ensure the application process is not delayed. We will complete the credentialing and onboarding process within 60 days of the receipt of a complete application.

Completion and submission of the application and the required documentation does not guarantee inclusion in any of our network(s).

If a provider is currently suspended or terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid Provider and therefore will not be considered for the Florida Community Care Provider Network.

Background Screening

No additional Level II screening is required of the provider because all providers must be Limited Enrolled or Fully Enrolled with Florida Medicaid. No additional Level II screening is required of an employee or volunteer of the provider who is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.).

Florida Community Care does not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.

Note: Applications must be fully completed and all documentation received by us to start the process of credentialing.

Provider Credentialing Requirements

Florida Community Care ensures that all providers are eligible for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements. (42 CFR 455.100-106; 42 CFR 455.400-470).

General Credentialing Requirements are as follows:

- All providers must have a current provider agreement with AHCA, as prescribed by AHCA.
- Each provider must have a NPI in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The NPI numbers must be submitted to FCC. Entities that do not meet the definition of "Health Care Provider" found at 45 CFR160.103 are not required to submit a NPI.
- Providers with a valid Limited Enrolled or Fully Enrolled agreement with AHCA will be deemed as having met the necessary requirements, including a Level II background check pursuant to s. 409.907, F.S.

Physicians must complete an application directly through the CAQH Universal Credentialing Data Source. Go to www.caqh.org/ucd_physician_faq.php for detailed information on how to create/edit your application with CAQH and to obtain a CAQH number.

Additional Provider Credentialing Requirements for providers submitting through CAQH are:

- Signed attestation statement (within 180 days)
- Copy of Florida license(s)
- Education and training, if applicable
- Work history for the past five years (explain gap of 6 +months)
- Copy of specialty board certificate, if applicable
- Hospital admitting privileges, if applicable
- Current certification of insurance (face sheet with expiration date and coverage amounts)
- Explanations for any malpractice history and disciplinary actions
- Copy of applicable certification(s), e.g., board certification, if applicable
- Explanations for any health issues
- Copy of Drug Enforcement Administration (DEA) license, if applicable
- Site Survey for all Primary Care Physicians

Required documentation as listed above must be faxed to CAQH at 1-866-293-0414.

Along with the application, additional documentation is required by Florida Community Care and varies depending on provider type and services to be rendered. These requirements will be disclosed to you during the contracting process, and collected by your Provider Relations Representative, if applicable.

Long-term Care Service Providers, Ancillary Facility/Supplier Business Credentialing Requirements

Long-term Care service providers, Ancillary Facility/Supplier Businesses and Ambulatory Service Centers (ASC) are not required to use CAQH. Said providers should complete and submit a credentialing application. The application will be provided to you by your Provider Relations Representative.

In addition to a completed application, you will be asked to submit the following, if applicable.

- Signed attestation statement (within 180 days)
- Copy of Florida license(s)
- Copy of Florida registration
- Current certification of insurance (face sheet with expiration date and coverage amounts) to include errors and omissions for General and Professional liability. If the insurance certificate covers multiple locations, it should either state that all locations owned by the corporate entity are covered OR have a roster of all covered locations attached.
- Explanations for malpractice history and disciplinary actions
- Copy of accreditation documentation, if applicable (ASCs must be accredited)
- If performing MRI, CT, PET, NC (includes cone beam CT), The Joint Commission, IAC or ACR accreditation is required
- If performing mammography services, ACR Accreditation is required
- Copy of applicable certification(s)
- Supervising physician statement, if applicable
- Copy of facility medical director's curriculum vitae, medical license, DEA certificate – if applicable
- Copy of Medicare certification(s), if applicable
- Copy of Medicare participation letter, if applicable
- AHCA and/or Centers for Medicare & Medicaid Services (CMS)/Medicare site survey. If not obtained, a Plan site visit is required. (Within 36 months prior to Credential Committee).

Assisted Living Facilities (ALF) and Adult Family Care Homes (AFCH)

Florida Community Care requires that ALFs and AFCHs conform to the HCB Settings Requirements. The ALF and AFCH will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

For enrollees of Florida Community Care residing in ALFs and AFCHs, the ALF and/or AFCH shall offer services with the following options unless, medical, physical, or cognitive impairments restrict or limit exercise of these options:

Choice of:

- Private or semi-private rooms, as available;

- Roommate for semi-private rooms;
- Locking door to living unit;
- Access to telephone and unlimited length of use
- Eating Schedule; and
- Participation in facility and community activities.

Able to have:

- Unrestricted visitation; and
- Snacks as desired

Ability to:

- Prepare snacks as desired; and
- Maintain personal sleeping schedule

All contracted ADHC providers shall conform to HCB Settings Requirements. The ADHC provider has agreed to support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

Adult Day Health Care Services (ADHC) providers have agreed to offer services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Daily activities;
- Physical environment;
- With whom to interact;
- Access to telephone and unlimited length of use;
- Eating schedule;
- Activities scheduled; and
- Participation in facility and community activities
- Ability to have:
    - Right to privacy;
    - Right to dignity and respect;
    - Freedom from coercion and restraint; and
    - Opportunities to express self through individual initiative, autonomy, and independence

Florida Community Care requires each LTC provider to develop and maintain policies and procedures for back-up plans in the event of absent employees, and that each provider maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees.

Florida Community Care will verify facility compliance through on-site reviews using the AHCA-prescribed HCB Settings Assessment and Remediation Tool, prior to offering the provider as an enrollee choice.

Florida Community Care will also monitor provider compliance with provider agreement requirements and take corrective action as necessary if we or the Agency for Health Care Administration (AHCA) conclude an ALF, AFCH or ADHC provider does not meet the HCB Settings Requirements.

- Upon discovery of non-compliance of HCB Settings Requirements, FCC will require the provider to remediate all areas of non-compliance within (10) business days of discovery. Documentation of the remediation will be submitted to AHCA as required.
- As per AHCA regulations, FCC will not place, continue to place, and/or provide reimbursement for enrollees residing in an ALF or AFCH, or receiving services from an ADHC provider who are non-compliant with the HCB Settings requirements.

Florida Community Care is required to report suspected unlicensed ALFs and AFCHs to the Agency for Health Care Administration. FCC requires its contracted providers to do the same.

Credentialing Requirements for Advanced Non-Physician Practitioners

Florida Community Care currently defines Advanced Non-Physician Practitioners (ANPP) as Advanced Registered Nurse Practitioners (ARNPs), Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs), and Registered Nurse First Assistants (RNFAs) who practice independently or as associates of a provider organization. Florida Community Care may expand this definition in the future to include other provider types.

Advanced Non-Physician Practitioners, as defined above, are required to obtain a Florida Community Care Plan provider number and register their National Provider Identifier (NPI) number with Florida Community Care.

It is the responsibility of the physician, physician group or facility to ensure that any employed or contracted Advanced Non-Physician Practitioners are properly licensed and supervised as may be required by law including, but not limited to Florida Statutes 458.347 (1) (f) and 464.012. They are also responsible for ensuring that employed Advanced Non-Physician Practitioners maintain proper licenses and credentials. Additionally, they must ensure that each Advanced Non-Physician Practitioner is enrolled with Florida Medicaid.

Recredentialing

Recredentialing is performed every three years or as otherwise required by law or applicable regulations and requires the submission of an updated credentialing application and documentation.

No additional Level II screening is required of the provider if the provider is a Limited Enrolled or Fully Enrolled Medicaid provider. No additional Level II screening is required of an employee or volunteer of the provider who is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.).

Hospitals are evaluated annually for state license, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, Det Norske Veritas (DNV) accreditation, Medicare certification, and sanction information. Site visits are conducted for non-accredited hospitals.

Failure to supply all requested documentation may result in the termination of your contract by Florida Community Care.

Updating Application Documentation

Providers have the right to review, correct and resubmit any of the information to support their credentialing application including but not limited to third party sources. Corrections must be submitted

by the date requested and, in all cases, no later than the completion date of the credentialing process. Delays in returning materials may result in the initiation of the contract termination process. Providers have the right to inquire about the status of their application. Information shared with Practitioners may include information obtained to evaluate their credentialing application, attestation or curriculum vitae (CV).

Note: Participating hospital-based physicians who practice exclusively in the hospital, skilled nursing facility and/or ambulatory service center settings are required to meet Florida Community Care credentialing requirements established under their respective contractual agreements. This credentialing requirement is typically met by fulfilling the requirements for being on staff where they provide services if the facility meets our credentialing requirements. The facility is required to be credentialed by us. If this requirement is not met, and or if any services are provided by a physician outside the above settings, then the physician is required to go through our credentialing process to participate in our networks.

Confirmation of Credentialing Status

Completed applications are verified and a determination made as to the applicant's participation with Florida Community Care. Once a determination is made, the Florida Community Care credentialing department will send all applicants written notice of the contracting status.

Applications may be delayed for any of the following reasons:

- Incomplete applications (all questions must be answered. Irrelevant questions must be answered as N/A)
- Missing documentation
- Expired documentation

Note: If you have completed and submitted all required documentation and haven't received any communication within 60 days, you may contact your Provider Relations Representative to obtain help with the process.

Minority Recruitment and Retention and Prohibition Against Discriminatory Practices.

Florida Community Care maintains a minority recruitment and retention plan in accordance with s. 641.217, F.S.

Florida Community Care does not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of provider's license or certification under applicable state law. (42 CFR 438.12(a)(1)). In addition, FCC does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments. (42 CFR 438.12(a)(2); 42 CFR 438.214(c)).

For more information on our minority recruitment and retention plan or our policy prohibiting discriminatory practices, please refer to our website at www.fcchealthplan.com.

Florida Community Care Provider Guidelines and Responsibilities

Provider Guidelines and Responsibilities

This section is an overview of guidelines and responsibilities for which all participating Florida Community Care Providers are accountable. Please refer to your contract or contact a Provider Relations Representative for clarification on any of the following.

Participating Florida Community Care Providers must, in accordance with generally accepted professional standards:

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973
- Agree to cooperate with Florida Community Care in its efforts to monitor compliance with its Medicaid contract(s), approved AHCA rules and regulations, and assist us in complying with corrective action plans necessary for us to comply with such rules and regulations
- Retain all agreements, books, documents, papers and medical records related to the provision of services to FCC enrollees as required by state and federal laws
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii).]
- Use physician extenders appropriately. Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) should provide direct enrollee care within the scope or practice established by the rules and regulations of the approved AHCA and FCC guidelines
- Cooperate in all respects with providers of other Managed Care Plans to assure maximum health outcomes for enrollees
- Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations
- Clearly identify physician extender titles (examples: MD, DO, ARNP, PA) to enrollees and to other health care professionals
- Honor at all times any enrollee request to be seen by a physician rather than a physician extender
- Provide all services in an ethical, legal, culturally competent manner, free of discrimination against enrollees based on age, race, creed, color, religion, gender identity, national origin, sexual orientation, marital, physical, mental, or socio-economic status
- Participate in and cooperate with Quality Improvement, Utilization Management, and other similar programs established by Florida Community Care, including allowing FCC to use provider performance data for quality improvement activities
- Participate in and cooperate with Florida Community Care's grievance procedures
- Comply with all federal and state laws regarding confidentiality of enrollee records
- Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services
- Maintain communication with appropriate agencies, such as local police, poison control, and social service agencies to ensure enrollees receive quality care
- Contact Florida Community Care case manager if an enrollee exhibits a significant change, is admitted to a hospital, or hospice program

- Respond promptly to FCC's request(s) for medical records in order to comply with regulatory requirements
- Maintain accurate medical records and adhere to all FCC's policies governing content and confidentiality of medical records
- Ensure that:
    - All employed physicians and other health care practitioners and Providers comply with the terms and conditions of the Agreement between Provider and FCC
    - To the extent physician maintains written agreements with employed physicians and other health care practitioners and Providers, such agreements contain similar provisions to the Agreement
    - Physician maintains written agreements with all contracted physicians or other health care practitioners and Providers, which agreements contain similar provisions to the Agreement
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to FCC, the Enrollee or the requesting party at no charge, unless otherwise agreed
- Meet all timely access standards pursuant to Agency for Health Care Administration standards
- Preserve Enrollee dignity and observe the rights of enrollees to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen
- Not discriminate in any manner between FCC enrollees and non-FCC enrollees
- Ensure that the hours of operation offered to FCC enrollees is no less than those offered to commercial enrollees or comparable Medicaid fee for service recipients if Provider serves only Medicaid recipients
- Not deny, limit or condition the furnishing of treatment to any FCC enrollee based on any factor that is related to health status, including, but not limited to, the following:
    - Medical condition, including mental as well as physical illness
    - Claims experience
    - Receipt of health care
    - Medical history
    - Genetic information
    - Evidence of insurability
    - Including conditions arising out of acts of domestic violence, human trafficking, or disability
- Freely communicate with and advise enrollees regarding the diagnosis of the enrollee's condition and advocate on enrollee's behalf for enrollee's health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self- administered regardless of whether any treatments are Covered Services
- Identify enrollees that need services related to children's health, human trafficking, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation, substance abuse or other behavioral health issues. If indicated, Providers must refer enrollees to Florida Community Care-sponsored or community-based programs by contacting the enrollee's case manager

- Immediately notify FCC of an enrollee's pregnancy, including the mechanism of doing so, whether identified through medical history, examination, testing, claims or otherwise
- Document the Referral to Florida Community Care sponsored or community-based programs in the enrollee's medical record and provide the appropriate follow-up to ensure the enrollee accessed the service
- Supply voluntary family planning, including a discussion of all methods of contraception, as appropriate
- Give all women of childbearing age HIV counseling and offer them HIV testing (Chapter 381, F.S.).
- Supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children
- Coordinate with the local WIC office to provide the above referral data from the most recent well- child visit. Any time a WIC referral is completed by a provider, a copy must be provided to the enrollee
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Agreement (which includes the most current Handbook)
- Accept payment, plus the enrollee's applicable deductible, coinsurance and/or copayment, as payment-in-full for covered services
- Not balance bill the enrollee for any differences between the charge and the contractual allowance. The enrollee is only responsible for any applicable deductible, coinsurance, and/or copayment and non-covered service amounts or services exceeding any benefit limitations
- Adhere to Florida Community Care business ethics, integrity and compliance principles and standards of conduct as outlined in the Plan's code of conduct
- Promptly notify us of claims processing payment errors
- Make such records and other information available to us or any appropriate government entity
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA-AS and HITECH requirements.
- Immediately notify us of adverse actions against license or accreditation status
- Maintain liability insurance in the amount required by the terms of your Agreement
- Notify us of the intent to terminate your Agreement as a participating provider within the timeframe specified in your Agreement

Maintaining Updated Provider Information

Florida Community Care shall maintain a provider directory in accordance with Agency requirements and specifications. The information below will be included and must be provided to Florida Community Care by participating providers.

It is important to maintain accurate and up-to-date provider demographics, office and billing information. Providers can notify Florida Community Care of any changes to their provider data records quickly and easily through their Provider Relations Representative.

Please note updating your provider information will not only ensure that we can reach you, but also ensure your current information is accessible to enrollees. Updates made to your provider record impact the information about your practice and/or services that display in the Florida Community Care Online Provider Directory.

Timely Notification of Changes to Provider Information

Please note that providers are required to notify Florida Community Care 30 days prior to the effective date of a change to ensure the plan has ample time to confirm and process the changes, and that accurate data is displayed in the provider directory. Prior notice is essential to avoid impacts to claims processing. Listed below are the data elements providers should keep up to date at all times, as applicable:

- Name / DBA Name / Legal Business Name
- Name changes, mergers or consolidations
- Practicing Specialty(ies)
- NPI
- Addresses (Payment, Service, Mailing)
- Contact Info
- Office Hours (including after hours and weekends)
- Staff Lists (Edit/ Add/Remove Providers)
- Practitioner Language(s)
- Staff Language Spoken
- Key Office Staff Updates
- Federal tax id number
- Add/Edit Credentials – Medicare, DEA, Medicaid number
- Medical Services by Location
- License(s) and Certification
- Hospital Privileges
- Hospital Affiliations
- PCP Panel Updates
- Website URL
- Communication Preferences
- PCMH Qualification
- Notification of no longer accepting new patients
- Gender of Patients serviced
- Age Restriction of patients serviced

Please review your information at www.fcchealthplan.com at least quarterly. If you find information that needs to be updated, please contact your Provider Relations Representative immediately.

Provider Prohibited and Permitted Marketing Activities

Florida Community Care provides full training on the correct way to conduct marketing activities. The requirements presented to network providers include the following:

Enrollee Information and Marketing

Any written informational and marketing materials directed at Florida Community Care enrollees must be developed at the fourth -grade reading level and have prior written consent from Florida Community Care and the appropriate government agencies. Please contact your Provider Relations Representative for information and review of proposed materials.

Florida Community Care providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in a Managed Care Plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the Managed Care Plan.
- Offer anything of value to induce recipients/enrollees to select them as their provider.
- Offer inducements to persuade recipients to enroll in the Managed Care Plan.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the Managed Care Plan for marketing activities
- Distribute marketing materials within an exam room setting.
- Furnish to any Managed Care Plan lists of their Medicaid patients or the membership of any other Managed Care Plan.
- Contracted Providers may:
    - Provide the names of the Managed Care Plans with which they participate.
    - Make available and/or distribute Managed Care Plan marketing materials outside of an exam room.

Florida Community Care providers may:

- Make available and/or distribute Managed Care Plan marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates.
- Distribute printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the providers contract. However, the Managed Care Plan shall ensure that:

  i. Materials do not "rank order" or highlight specific Managed Care Plans and include only objective information.
  ii. Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution.

iii. The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials.
iv. Providers are also permitted to display posters or other materials in common areas such as the provider's waiting room.
v. If a provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates.

- Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.
- To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
- Share information with patients from the Agency's website or CMS' website.
- Announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites)
- Make new affiliation announcements within the first thirty (30) calendar days of the new provider agreement.
- Make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts. Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.

Florida Community Care provides full training on the correct way to conduct marketing activities. Please contact your Provider Relations Representative for additional information.

Fraud, Waste and Abuse

Florida Community Care maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. Florida Community Care is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with us.

We regard health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. We have implemented a program to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care. The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment. The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or Acts in reckless disregard of the truth or falsity of the information in a claim. The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Florida False Claims Act

Florida has also enacted a state False Claims Act (F.S. Title VI, §§ 68.081-68.089) in 2007 to allow for the recovery of state funds in addition to federal funds for false claims. The provisions of the Florida False Claims Act (FFCA) are similar, but not identical to, the provisions of the federal FCA. The FFCA provides for civil penalties of not less than $5,500 and not more than $11,000 per violation, for three times the damages to state government due to false claims, and for recovery of attorney's fees and court costs.

Deficit Reduction Act

On February 8, 2006, the Deficit Reduction Act ("DRA") was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs. Health care entities like Florida Community Care who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblower.

Whistleblower Protection

The Federal False Claims Act, the Florida False Claims Act, and the Medicaid False Claims Act have language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently.

Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government. Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Florida Community Care will take steps to monitor contracted providers to ensure compliance with the law.

Definitions

Fraud:

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Waste:

Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

Abuse:

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary
- Balance Billing a Medicaid enrollee for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "upcoding", and billing for services not provided.
- Concealing patients misuse of Florida Community Care identification card.
- Failure to report a patient's forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)

Florida Community Care provides full training on the fraud, waste and abuse. Please contact your Provider Relations Representative for additional information.

Abuse, Neglect and Exploitation

Long-Term Care: Abuse, Neglect, and Exploitation

Florida Community Care requires that all direct service providers complete Abuse, Neglect, and Exploitation Training. This training may be provided by the Department of Children and Families, the local area agency on aging, the Department of Elder Affairs, or through licensing requirements.

Department of Children and Families
1317 Winewood Blvd
Bldg 5 – Room 203
Tallahassee, FL 32399-077
Phone: (850)-488-1429

"**Abuse**" means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee's physical, mental, or emotional health. Abuse includes acts and omissions.

"**Exploitation**" of a vulnerable adult means a person who:

- Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property for the benefit of someone other than the vulnerable adult.
- Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

"Neglect" of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term "neglect" also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

"Neglect" of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, behavioral, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number **(800) 96ABUSE.**

Florida Community Care provides full training on abuse, neglect and exploitation. Providers must complete abuse, neglect, and exploitation training, including training to identify victims of human trafficking. Please contact your Provider Relations Representative for additional information.

Adverse and Critical Incidents Reporting –

Providers must report adverse incidents including events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents to us no more than twenty-four (24) hours from the incident.

Adverse Incidents are unexpected occurrences in connection with services that led to or could have led to serious unintended or unexpected harm, loss or damage, such as death or serious injury, to an individual receiving service through Florida Community Care or any third party that becomes known to the plan's staff. Adverse and Critical Incidents must be reported by both providers and vendors.

A Critical Incident as defined by the Agency for Health Care Administration (AHCA): "Critical events that negatively impact the health, safety, or welfare of enrollees. Critical Incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents." This may result in, but is not limited to, the following:

- Death
- Abuse/neglect/exploitation
- Major medication incident
- Altercation requiring medical intervention
- Involvement with law enforcement
- Enrollee elopement/missing
- Enrollee major injury
- Enrollee major illness

According to the Adverse Incident Reporting Guide distributed by AHCA, the term "Adverse Incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and results in one of the following injuries:

- Death
- Brain or spinal damage
- The performance of a surgical procedure on the wrong patient
- The performance of a wrong surgical procedure
- The performance of a wrong-site surgical procedure
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
- The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure

If either an Adverse or Critical Incident is identified, the providers must report the incident. The Critical/Adverse Incident Form is located on our website at: www.fcchealthplan.com.

To report a critical incident, provider should email the Critical/Adverse Incident Form to: incidentreporting@fcchealthplan.com.
or the form may be faxed to: 1-305-675-9285.

For any incidents that occur on the weekends (after 5 p.m. Friday), and on holidays, providers must also report the incident immediately to the critical incident email box: incidentreporting@fcchealthplan.com

FCC does not require nursing facilities or ALFs to report Critical Incidents or provide incident reports to the Plan. Critical Incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida Law, including but not limited to ss.400.147 and 429.23, F.S. and Chapters 39 and 415 F.S.

Primary Care Provider's Responsibilities

Florida Community Care will ensure a sufficient selection of PCPs in each of the following four (4) specialty areas within the geographic access standards:

- Family Practice
- General Practice
- Pediatrics; and
- Internal Medicine

All FCC PCPs shall provide, or arrange for, coverage of services, consultation, or approval for referrals twenty-four hours per day, seven days per week (24/7) by a Medicaid-enrolled PCP. After hours coverage must be accessible using the medical office's daytime telephone number. After hours coverage shall consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render clinical decision or reach the PCP for a clinical decision.

All FCC PCPs shall arrange for coverage of primary care services during PCP absence due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

All PCP providers who have executed their FCC Provider Service agreement fully accept and agree to all responsibilities and duties associated with the PCP designation.

FCC shall annually inform PCP providers of the availability of healthy behavior programs, child wellness requirements, and case management services to support enrollee engagement and coordinated care.

Provider Responsibilities When Agreement Is Terminated

As outlined in our agreement, providers must continue to support enrollees as follows:

- Continue to provide services to enrollees who are receiving inpatient services until they are appropriately discharged and/or the specific episode of care is completed.
- Provide for continuity of care for the course of treatment in the event of termination during the course of an enrollee's treatment
- Accept payment at rates in effect under the Agreement immediately prior to termination.
- Continue providing medically necessary services if the termination was a not-for-cause termination and submit claims for services rendered to such enrollees until the enrollees select another provider, for a minimum of sixty (60) days after the termination of the agreement. A terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

Managed Medical Assistance Benefits and Services

As of the date of publication of this Handbook, the following core benefits and services (Covered Services) are provided to Florida Medicaid Enrollees under the MMA Benefit:

Service	Description	Coverage/Limitations	Prior Authorization
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover blood or skin allergy testing and up to 156 doses per year of allergy shots	Yes
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary.	Yes
Ambulatory detoxification services	Ambulatory setting substance abuse treatment or detoxification services	All enrollees (18 years of age and older 3 hours per day for up to 30 days	Yes
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary.	Yes
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary.	No
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year,	No
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover: - One initial assessment per year - One reassessment per year - Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	Yes

Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor: - Cardiac testing - Cardiac surgical procedures - Cardiac devices	Yes
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover: - One new patient visit - 24 established patient visits per year - X-rays	No
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic	Visit to a federally qualified health center or rural health clinic visit	No
Crisis Stabilization Units and Class III and Class IV Freestanding Psychiatric Hospitals	Inpatient treatment at Crisis Stabilization Unit	All enrollees (18 years of age and older) 365 days for under 21 and 45 days for 21 and older excluding emergency services/Baker Act	Yes; services provided under Baker Act are not subject to prior authorization
Community-Based Wrap-Around services	Community-Based wrap around services	For enrollees 18 years of age to 20 8-10 hours of treatment per week for 2 to 4 months	Yes
Detoxification or Additions Receiving Facilities	Hospital based inpatient detoxification	All enrollees (18 years of age and older) Limit of 365 days for 18 years of age through 20 and 45 days for 21 and older	Yes
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor: - Hemodialysis treatments - Peritoneal dialysis treatments	Yes
Drop-In Center	Day care services, per day; mental health program	For enrollees 21 years of age and older Limit of 365 days per year	Yes
Durable Medical Equipment and	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment	Some service and age limits apply. Call 1-833-FCC-PLAN for more information.	Yes

Medical Supplies Services	is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away		
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary.	No
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover: - One adult health screening (check-up) per year - Well child visits are provided based on age and developmental needs - One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover: - Up to 26 hours per year	Yes
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: - Covered as medically necessary	No, except in office procedures
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: - Covered as medically necessary	No, except in office procedures
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover: - Up to 39 hours per year	Yes
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor: - Cochlear implants - One new hearing aid per ear, once every 3 years - Repairs	Yes

Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover: - Up to 4 visits per day for pregnant recipients and recipients ages ~~0~~18-20 - Up to 3 visits per day for all other recipients	Yes
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	- Covered as medically necessary	Yes
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover: - Up to 26 hours per year	Yes
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation: - Up to 365/366 days for recipients ages 8-20 - Up to 45 days for all other recipients (extra days are covered for emergencies)	Yes
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	- Covered as medically necessary	No, except in office procedures
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	- Covered as medically necessary	No
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	- Covered as medically necessary	Yes
Medication Management Services	Services to help people understand and make the best choices for taking medication	- Covered as medically necessary	Yes

Mental Health Partial Hospitalization Program	Mental health partial hospitalization treatment, less than 24 hours	For enrollees 21 years of age and older Up to 30 days annually	Yes
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Yes
Mobile Crisis Assessment and Intervention for Enrollees in the Community	Psychiatric health facility service, per day	All enrollees (18 years of age and older) Up to 2 hours per day and 24 hours per year	No
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	- Covered as medically necessary	No, except in office procedures
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: - Out-of-state travel - Transfers between hospitals or facilities - Escorts when medically necessary	Yes
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term; these services can be used instead of going to the hospital in some cases	- We cover 365/366 days of services in nursing facilities as medically necessary - See information on Patient Responsibility for copayment information	Yes
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 18-20 and for adults under the $1,500 outpatient services cap: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes

Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	- Covered as medically necessary	Yes
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	- Covered as medically necessary	Yes
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	- Emergency services are covered as medically necessary - Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	Yes
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	- Covered as medically necessary. Some service limits may apply	Yes
Partial Hospitalization Services in a Hospital	Psychiatric/Psychological services; partial hospitalization – less intensive	For enrollees 21 years of age and older Up to 30 days per year	Yes
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 18-20 and for adults under the $1,500 outpatient services cap: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes
Podiatry Services	Medical care and other treatments for the feet	We cover: - Up to 24 office visits per year - Foot and nail care - X-rays and other imaging for the foot, ankle and lower leg - Surgery on the foot, ankle or lower leg	Yes

Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover: - Up to a 34-day supply of drugs, per prescription - Refills, as prescribed	No
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover: - Up to 24 hours per day	Yes
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover: - 10 hours of psychological testing per year	Yes
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover: - Up to 480 hours per year	Yes
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays	- Covered as medically necessary	Yes
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary	Yes
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential,	Yes
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover: - Respiratory testing - Respiratory surgical procedures - Respiratory device management	Yes
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover: - One initial evaluation per year - One therapy re-evaluation per 6 months	Yes

		- Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	
Self-Help/Peer Services	Self-helper/peer services, per 15 minutes	All enrollees (18 years of age and older) 4 hours per day allowed; 40 hours per year	Yes
Specialized Therapeutic Services	Services provided to children ages 18-20 with mental illnesses or substance use disorders	We cover the following: - Assessments - Foster care services - Group home services	Yes
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following services for children ages 18-20: - Communication devices and services - Up to 210 minutes of treatment per week - One initial evaluation per year We cover the following services for adults: - One communication evaluation per 5 years	Yes
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 18-20	Yes
Substance Abuse Intensive Outpatient Program	Alcohol and/or drug services; intensive outpatient	All enrollees (18 years of age and older) Daily, up to 4 days per week for 9 weeks	Yes
Substance Abuse Short-Term Residential Treatment	Behavioral health; short-term residential (non-hospital residential treatment program) without room and board	For enrollees 21 years of age and older Up to 30 days per year	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover: - Up to 9 hours per month	Yes
Transplant Services	Services that include all surgery and pre and post-surgical care	Covered as medically necessary	Yes

Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following services when prescribed by your doctor: - Two pairs of eyeglasses for children ages 18-20 - Contact lenses - Prosthetic eyes	Yes
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	- Covered as medically necessary	Yes

Early and Periodic, Screening, Diagnosis and Treatment (EPSDT)

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under the age of 21 years, as specified in Section 1905(a)(4)(B) of the Social Security Act (the Act) and defined in 42 U.S.C. § 1396d(r)(5) and 42 CFR 441.50 or its successive regulation. The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

FCC, as an LTC Plus plan, provides coverage for enrollees 18 years of age and older. As such, FCC provides coverage consistent with all EPSDT Agency requirements for their Medicaid enrollees from the ages of 18 through 20 years of age. EPSDT entitles the specified Medicaid enrollees to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions.

FCC, for Medicaid eligible children from the ages of eighteen through twenty (20) years old, pays for any other medically necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the plan. (42 U.S.C. 1396d(r)(5)).

FCC does not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children from the ages of eighteen through twenty (20) years old. FCC maintains a special services process to authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary.

FCC has processes for authorization of any medically necessary service to enrollees from the ages of eighteen through twenty (20) years old, in accordance with Section 1905(a) of the Social Security Act, when: (1) The service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or (2) Is not a covered service of the plan; or (3) The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Clean claims that meet all the requirements of EPSDT will auto-adjudicate without examiner intervention when:

a. Clean claims that meet all the requirements of EPSDT will auto-adjudicate without examiner intervention
    - Age – 18 to 20 years
    - EPSDT Referral Code
        - AV = Available-not used (recipient refused referral)

- NU = Not used (no EPSDT recipient referral given)
- S2 = Under treatment (recipient currently under treatment for referred diagnostic or corrective health problem)
- ST = New service requested (recipient referred to another provider for diagnostic or corrective treatment or scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals)

  - Diagnosis Code – appropriate diagnosis code to the highest level of specificity that supports medical necessity
  - Procedure Code – as incorporated by reference in Rule 59G-4.002, F.A.C (Physician Fee schedule)
  - Modifier(s) – EP – billed with procedure code for child health check-up recipients between the ages of 18 to 20 years

b. Claims that do not meet all the requirements (above) of EPSDT will suspend for UM review
c. Claims that have been reviewed by UM will be processed as determined by UM.

Florida Community Care Provider Relations will provide training ensuring that all providers are knowledgeable about ESPDT requirements. Provider training will include the EPSDT schedule and recommended developmental and other screenings. The provider portal will include written reference materials on immunization and screening schedules, as well as EPSDT guarantees.

Providers who are identified through enrollee complaints or other monitoring as lacking in EPSDT knowledge will be flagged for additional training and technical assistance from the Provider Relations Representative.

Long-term Care Benefits and Services

As of the date of publication of this Handbook, the following core benefits and services (Covered Services) are provided to Florida Medicaid Enrollees under the LTC Benefit:

Service	Description	Prior Authorization
Companion Care	This service helps you fix meals, do laundry and light housekeeping	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during meal times, you can eat there.	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.

Assistive Care Services	These are 24-hour services if you live in an adult family care home or an assisted living facility	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Behavioral Management	Services for mental health or substance abuse needs	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Caregiver Training	Training and counseling for the people who help take care of you	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.

	bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	
Home Delivered Meals	This service delivers healthy meals to your home	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.

	and then thrown away, like bandages, gloves, and other items.	
Medication Administration	Help taking medications if you can't take medication by yourself	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Medication Management	A review of all of the prescription and over-the-counter medications you are taking	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Home.	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.

Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.
Transportation	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	Authorization is provided based on the enrollee's plan of care. Contact the enrollee's care manager for assistance at 1-833-FCC-PLAN.

All covered services must be authorized by Florida Community Care prior to being rendered. Any changes to covered services will be communicated through updates to this Handbook, and/or contractual amendments

Florida Community Care Expanded Benefits and Services

FCC shall administer the expanded benefits of Medicaid covered services in accordance with any applicable service standards pursuant to the Agency contract by which it's bound, the applicable federal waivers, and any Florida Medicaid Coverage and Limitations Handbooks and Medicaid Coverage Policies.

FCC offers the following expanded benefits:

- Over-the-counter (OTC) Medication/Supplies

- Occupational Therapy
- Physical Therapy
- Hearing benefits for adults
- Vision benefits for adults
- Prenatal/Perinatal Visits
- Respiratory Therapy
- Speech Therapy
- Primary Care Visits (Non-Pregnant Adults)
- Cellular Phone Services
- CVS Discount Program
- Durable Medical Equipment/Supplies
- Medically Related Home Care Services/Homemaker
- Home Delivered Meals - Disaster Preparedness/Relief
- Housing Assistance
- Vaccine – Influenza
- Vaccine – Shingles
- Vaccine – Pneumonia
- Acupuncture
- Chiropractic Services
- Waived Co-payments
- Assisted Living Facility/Adulty Family Care Home – Bed Hold Days
- Transition Assistance – Nursing Facility to Community Setting

FCC's expanded benefits may be changed on a Contract year basis in a manner and format approved by the Agency, if determined by the Agency to be beneficial to the enrollees.

FCC may increase its expanded benefits upon approval by the Agency.

FCC may exchange an expanded benefit for another, if determined to be actuarially equivalent by the Agency, upon approval by the Agency.

In Lieu Of Services Provision

FCC may, as per Agency contract and in accordance with 42 CFR 438.3(e)(2), cover services or settings that are in lieu of services or settings covered under the plan. FCC will use a clinical rationale for determining the benefit of the in lieu of service for the enrollee. The enrollee will have a choice to receive the Medicaid covered service or "in lieu of" service. The choice must be documented in the enrollee record.

A copy of FCC In Lieu of Services Procedures can be found on our website at www.fcchealthplan.com.

Telemedicine Coverage Provisions

In accordance with Rule 59G-1.057, F.AQ.C, FCC has opted to provide Telemedicine Services.

FCC will offer its enrollees a choice to access services through telemedicine and/or through face to face encounter. Telemedicine providers are required to adhere to all applicable rules and regulations. FCC telemedicine providers must be in compliance with the Health Insurance Portability and Accountability Act as well as state and federal laws governing patient privacy. All telecommunication equipment and

telemedicine services must meet the technical safeguards required by 45 CFR 164.312. FCC provides appropriate training as applicable to all telemedicine providers.

Any provider approved by FCC to provide telemedicine services through their FCC provider agreement, must have protocols to prevent fraud and abuse that address:

- Authentication and authorization of users;
- Authentication of the origin of the information;
- The prevention of unauthorize access to the system or information;
- System security, including the integrity of information that is collected, program integrity and system integrity; and
- Maintenance of documentation about system and information usage.

Utilization Management Program

The FCC Utilization Management (UM) Program is made up of the utilization management services FCC provides enrollees and providers. This utilization management program applies to the management of Managed Medical Assistance (MMA) services and home and community based Long Term Care (LTC) services. The FCC UM program is integrated internally and externally to deliver the maximum effectiveness for enrollees, providers, and external stakeholders.

Utilization Management Philosophy and Goals

Utilization Management Philosophy

FCC's utilization management philosophy is enrollee-centric and collaborative with enrollees and providers to address an enrollee's physical, behavioral, environmental, and social needs. We strive to achieve a seamless integration with our external subcontractors and any external stakeholders for a unified experience for enrollees and providers.

The mission is to optimize the health outcomes and effectiveness for enrollees in order to enhance the quality of life and health through a choice of cost-effective resources and services tailored to meet the enrollee's clinical as well as psycho-social and financial needs.

Program Goals

The goals of the FCC UM program are as follows:

- Develop and maintain the UM program within the organization.
- Improve transitions of care across health care settings, providers, and services.
- Optimize enrollee's health status, sense of well-being, and productivity by rendering quality services.
- Monitor overutilization, underutilization, and inappropriate use of services through regular care plan and service utilization reviews.
- Improve clinical outcomes for enrollees with complex health conditions and social situations thereby reducing unnecessary costs.
- Optimize health care utilization by assisting practitioners/providers with tools, resources, and information to better manage their patients.
- Promote practitioner/provider compliance with evidence-based clinical guidelines and applicable standards of care.

UM Scope and Processes

Communication Services

Providers submit requests for service authorizations for review by the FCC UM Department via fax or phone and may inquire on authorization status on the Provider Portal as follows:

-Fax: 1-305-675-6138
-Phone: 1-833-FCC-PLAN, Option 2
-Provider Portal for authorization status: www.fcchealthplan.com

The UM staff are available to respond to requests for service authorization from 8am-5pm, Monday through Friday, in the time zone where enrollees and providers operate. Staff also have access to TTY and translation services to respond to a request from an enrollee with special needs. After business hours, providers can reach the general provider help line which is available 24 hours a day, 7 days per week. A member of the provider helpline staff contacts an on-call member of the UM staff for urgent requests. Staff respond to all service authorization requests received during business hours within one business day. A response is defined as a confirmation that the request has been received and will be reviewed for determination.

When responding to requests for service authorization, UM staff identify themselves with their name, title, and organization name. Upon request, UM staff inform enrollees and providers about standard utilization management processes.

Clinical Information

If the provider, via fax or web portal, submits clinical information such as labs, images, or clinical notes, the authorization representative attaches the information to the case in the FCC medical management system for review by the licensed staff. If the provider submits the service authorization request telephonically, a licensed staff may review the request immediately for determination upon request. Licensed staff are available to non-clinical authorization representatives during authorization intake for any questions. Non-clinical staff inform providers of any request that does not require authorization however, they do not issue denials of any kind.

When conducting a review of a service authorization request, FCC accepts information from any reasonably reliable source that will assist in the authorization process. Any treating provider may submit information for the authorization request. Authorization staff collect only the information necessary to authorize the admission, procedure or treatment, length of stay, or frequency or duration of services.

All UM determinations are made solely on the medical information obtained at the time of the review determination. For a retrospective request, determinations are based on the medical information available at the time the care was provided. UM determinations are made based solely on the appropriateness of care, service, and existence of coverage. FCC does not specifically reward practitioners or other individuals for issuing denials of coverage nor do any financial incentives for UM decision makers encourage decisions that result in underutilization.

Medical Necessity for Managed Medical Assistance (MMA) Services

FCC reviews MMA services and specific LTC services (i.e., nursing facility services, assistive care services, attendant nursing care services, hospice services, intermittent skilled nursing services, medical equipment and supplies, personal care, acute therapy services, and transportation to LTC services) for medical necessity in compliance with Rule 59G-1.010, F.A.C. Medical necessity is defined as:

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

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

In accordance with 42 U.S.C. § 1396d(r)(5), FCC, for Medicaid eligible children under the age of twenty- one (21) years, pays for any "other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." (42 U.S.C. 1396d(r)(5)) FCC does not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21) years. FCC has a special services process to authorize services exceeding the coverage described in each service-specific coverage policy, if medically necessary which includes FCC Medical Director review of all requests for non-covered services for children under the age of 21. The Medical Director review ensures any medically necessary service is covered in compliance with EPSDT requirements.

Medical Necessity for Long Term Care (LTC) Services

FCC reviews LTC services for medical necessity in compliance with the AHCA ITN-17/18, Attachment B, Exhibit B-2, Section VI.A.1. A medically necessary LTC service must:

- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;

- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider;
- And, one of the following:
    - Enable the enrollee to maintain or regain functional capacity; or
    - Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of his or her choice.

Prior Authorization

The prior authorization process applies to requests initiation or continuation of services such as outpatient services, elective hospitalizations, and medical procedures. The provider submits a service authorization request before the enrollee receives the requested care. The prior authorization function is used for the following purposes:

- To confirm the service is provided in an appropriate level of care and place of service.
- To confirm the service is a covered benefit, clinically appropriate, provided timely, and is cost effective.
- To ensure the service is coordinated as necessary with other internal departments or external stakeholders.
- To ensure the service is accurately documented and verified to facilitate accurately and timely reimbursement for the provider.

Prior authorization nurses review all pre-service requests for medical necessity. If they are unable to determine medical necessity, the case is referred to the Medical Director for review. Prior authorization nurses do not issue denials for lack of medical necessity; however, they may issue administrative denials based on benefits or lack of clinical information. The Medical Director reviews all available clinical information in the case and makes a determination regarding the medical necessity of the case. If appropriate, the Medical Director contacts the requesting provider to obtain any additional information and consult on the case as needed. The Medical Director may consult physician specialists in a specific area as needed as well.

Once the Medical Director reaches a determination, he forwards the case back to the prior authorization nurse to process the determination. If the determination is adverse, the prior authorization nurse processes the Notice of Adverse Benefit Determination for mailing to the enrollee with a copy also sent to the provider. In addition, the prior authorization nurse contacts the provider’s office to provide verbal notification of the adverse benefit determination. The prior authorization nurse notifies the provider that a peer to peer reconsideration can be requested within one business day. If the peer-to-peer reconsideration results in an approval, the prior authorization nurse processes the approval. If the peer- to-peer reconsideration results in an adverse benefit determination, the prior authorization nurse processes the adverse benefit determination.

Concurrent Review

Concurrent Review is the process of evaluating admissions and continued stay requests when an enrollee is hospitalized. Licensed staff review all admission and continued stay requests for medical necessity and appropriate utilization of inpatient resources. During the concurrent review process, licensed staff also identify occurrences of over/underutilization, physician practice patterns, ways to improve enrollee outcomes, and monitor cost effectiveness. The concurrent review process is used for the following functions:

- To assess the medical necessity of admissions and continued stays, the appropriateness of the admission, the cost effectiveness of the setting, level of care, and services.

- To estimate the probable and goal length of stay of the admission.
- To monitor the services to determine if they are provided timely and efficiently.
- To screen for potential quality of care, utilization, and risk issues.
- To begin discharge planning early in the inpatient stay to satisfy transition of care needs.
- To work with hospital staff to recommend alternate care options as appropriate.
- To identify and refer enrollees to case management or disease management services.
- To identify clinical issues in the enrollee and refer to the Medical Director for discussion with the enrollee's primary care physician or treating physician.
- To identify quality of care concerns and refer to the Medical Director for discussion with the attending staff, hospitalist, and/or risk management staff.
- To communicate with facility staff and other providers to coordinate the enrollee's care.

In general, concurrent review nurses review requests for admission and continued stay at inpatient hospitals, inpatient hospices, inpatient rehabilitation centers, and nursing facilities. Concurrent review staff review and respond to requests for admission telephonically within 24 hours. Staff complete follow- up reviews based on authorized days and a mutually agreed upon schedule with the hospital. FCC staff request follow-up reviews based on the severity or complexity of the enrollee's condition or based on necessary treatment/discharge planning needs. FCC does not complete on-site concurrent reviews. In general, concurrent review nurses review requests for continued stay on the last covered day of admission.

Emergency admissions do not require authorization for the observation/stabilization period (up to 24 hours). Admission to the hospital and/or continued stay beyond 24 hours requires authorization.

Concurrent review nurses review all admission and continued stay requests for medical necessity. If they are unable to determine medical necessity, the case is referred to the Medical Director for review. Concurrent review nurses do not issue denials for lack of medical necessity; however, they may issue administrative denials based on benefits or lack of clinical information. The Medical Director reviews all available clinical information in the case and makes a determination regarding the medical necessity of the case. If appropriate, the Medical Director contacts the requesting provider to obtain any additional information needed. The Medical Director may consult physician specialists in a specific area as needed.

Once the Medical Director reaches a determination, he or she forwards the case back to the concurrent review nurse to process the determination. If the determination is adverse, the concurrent review nurse processes the Notice of Adverse Benefit Determination for mailing to the enrollee with a copy to the provider. In addition, the concurrent review nurse contacts the provider's office or facility to provide verbal notification of the adverse determination. The concurrent review nurse notifies the provider that a peer- to-peer reconsideration can be requested within one business day. If the peer-to-peer reconsideration results in an approval, the concurrent review nurse processes the approval. If the peer-to-peer reconsideration results in an adverse determination, the concurrent review nurse processes the adverse determination.

Authorization of Long-Term Care (LTC) Services

The utilization management process for LTC services encompasses the following program components: person-centered assessment, service planning, and medical necessity review. FCC conducts a comprehensive assessment of the enrollee prior to the development of the initial plan of care. FCC reviews and utilizes Agency-required forms and the LTC supplemental assessment form, as defined in Rule 59G-4.193, F.A.C. when completing the initial comprehensive assessment of the enrollee. The care

manager generates a service plan guided by the assessment that may be reviewed with all appropriate stakeholders inclusive of the enrollee and/or caregiver, Primary Care Physician, and the Interdisciplinary Care Team and its members. The process is complete when a service determination has been made and communicated appropriately.

Each enrollee with LTC needs is assigned a care manager as a point person to ensure that enrollee needs are identified and services are coordinated. The Care Manager along with the Care Coordinator work as a team in conjunction with other staff involved in the UM processes.

For specific LTC services requiring authorization, information is collected from the providers involved and FCC care managers complete the medical necessity review. LTC care managers are able to authorize, if required, the following services: adult companion care, adult day health care, assisted living, behavioral management, care coordination/case management, caregiver training, home accessibility adaptation, home delivered meals, homemaker services, medication administration, medication management, nutritional assessment or risk reduction, personal care, in-home respite care, maintenance therapies, medical equipment under $500, and transportation services. If an enrollee requires an MMA or LTC service requiring UM team review, the care manager works with the UM team to facilitate review of the requested service. When the FCC care managers are unable to determine medical necessity for an LTC service using the established guidelines, staff refer the cases to the Medical Director for review and determination. Only a Medical Director may issue a denial of service based on medical necessity.

FCC care managers finalize the plan of care at the initial face-to-face visit with the enrollee and applicable caregivers. The finalized plan of care includes all services, including frequency, duration, and amount, that the FCC care manager and the enrollee agree upon during the initial face-to-face visit. FCC sends authorizations to all applicable providers for the agreed upon services, including frequency, duration, and amount, within 24 (twenty-four) hours of the initial face-to-face visit.

If FCC care managers are unable to reach an enrollee to complete the plan of care, care managers follow the established unable to reach processes to locate the enrollee. If the enrollee has services already in place through a prior plan of care, the existing services will be authorized until the enrollee can be reached. If a provider, in treating the enrollee, requests authorization for services, the care manager or UM team will review the requested services medical necessity and process accordingly. In addition, the care manager will coordinate efforts to locate the enrollee with the treating provider. FCC does not deny covered services based on an incomplete plan of care.

FCC care managers ensure service authorizations are consistent with the services documented on enrollee's plan of care, including the frequency and duration necessary to support the enrollee adequately and safely in the setting of his or her choice. FCC uses a person-centered care planning approach to ensure all services are consistent with the enrollee's goals. In addition, care plans undergo auditing by management staff to ensure service authorizations are consistent with the enrollee's documented goals.

FCC care managers authorize ongoing services within the timeframes specified in the enrollee's plan of care. Care managers process service authorization requests for respite services requested on an emergent basis within the expedited timeframes specified in Attachment B., Section VI.G., Authorization of Services.

FCC UM staff or care managers may determine the duration for which services will be authorized, except as follows:

(1) Maintenance therapies, as defined in Rule 59G-4.192, F.A.C., shall be authorized for no less six (6) months on the enrollee's plan of care. The authorization must be supported by the results from the comprehensive assessment or objective LTC evidence-based criteria.

(2) All other covered services that are authorized for a duration of less than six (6) months must be for the treatment of an acute illness or a condition that will be resolved within six (6) months. The authorization decision must be supported by the PCP's prescription of the service for a shorter duration or, in the case of services that do not require a PCP's prescription, the authorization decision must be supported by objective evidence-based criteria.

(3) The authorization time period shall be consistent with the end date of the services as specified in the plan of care.

Second Opinions

FCC allows enrollees to obtain a second medical opinion in any instance in which the enrollee disputes FCC's or the physician's opinion of the reasonableness or necessity of a covered service or is subject to a serious injury or illness at no expense to the enrollee and authorizes claims for such services in accordance with 42 CFR 438.206(b)(3) and s. 641.51, F.S.

The second opinion, if requested, is provided by a physician chosen by the enrollee who may select a participating physician listed in the FCC provider directory that is provided by the organization or a nonparticipating physician located in the same geographical service area of the organization.

FCC pays the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with FCC. FCC may require that any tests deemed necessary by a nonparticipating physician be conducted by a participating physician. FCC may deny reimbursement rights granted under this section in the event the enrollee seeks in excess of three such referrals per year if such subsequent referral costs are deemed by FCC to be evidence that the enrollee has unreasonably overutilized the second opinion privilege. An enrollee denied reimbursement under this section has recourse to grievance procedures as specified in ss. 641.495 and 641.511.

Retrospective Review

Retrospective review is the process of completing a medical necessity review after a service has already been initiated or completed. Retrospective reviews occur when FCC has not been notified of an inpatient admission, a prior authorization was not obtained due to the enrollee's condition at the time the service was provided, or primary insurance eligibility was misidentified. Prior to completing a retrospective review, the prior authorization nurse confirms the enrollee's eligibility and benefits at the time the service was initiated or rendered.

Prior authorization nurses review all retrospective authorization requests for medical necessity. When considering a retrospective authorization request, the nurse reviews information available to the provider at the time the service was initiated or rendered. If they are unable to determine medical necessity, the case is referred to the Medical Director for review. The Medical Director reviews all available clinical information in the case and makes a determination regarding the medical necessity of the case. If

appropriate, the Medical Director contacts the requesting provider to obtain any additional information and consult on the case as needed. The Medical Director may consult physician specialists in a specific area.

Once the Medical Director reaches a determination, he or she forwards the case back to the prior authorization nurse to process the determination. If the determination is adverse, the prior authorization nurse processes the denial notice for mailing to the enrollee with a copy also sent to the provider. In addition, the prior authorization nurse contacts the provider’s office to provide verbal notification of the adverse determination. The prior authorization nurse notifies the provider that a peer-to-peer reconsideration can be requested within one business day.

Notice of Certification

When UM staff issue a certification for a requested service, either through pre-service, concurrent review, or retrospective review, they provide notification to the attending physician or ordering provider, rendering facility, and enrollee via fax or phone, depending on the type of request. This notification includes CPT/HCPCS codes authorized, effective dates for the authorization and an authorization number for tracking purposes. For non-participating providers, FCC provides the notice of certification for services within one business day of the approval. For concurrent review requests, the notification also includes the number of days or units authorized on the review, the next review date, total number of days or units authorized, and the date of admission or start date of services.

Reversal of Certifications

When UM staff issue a certification for a requested service, FCC does not reverse a certification of a request unless staff receive new information relevant to the request that was not available at the time of the original determination.

Discharge Planning

Discharge planning is a proactive process that begins at admission. Clinical staff, by assessing the enrollee’s condition, anticipate possible discharge needs to ensure the enrollee’s treatment team promptly implements the plan of care. Discharge planning provides transition from the inpatient setting to the enrollee’s next level of care (e.g., nursing facility, home, long-term care). When creating the discharge plan, the concurrent review nurse considers the enrollee’s entire continuum of care as well as the enrollee’s benefit coverage.

The discharge planning team may include the concurrent review nurse, the care manager if assigned, the hospital discharge planner, the enrollee’s primary care physician, other treating providers, the enrollee, and the enrollee’s family or representative. The discharge planning team considers a number of factors when creating the discharge plan, including, but not limited to, the enrollee’s age, prior level of functioning, past medical history, current medical conditions, current level of functioning, family and community support, psychosocial factors, and possible barriers. A complete discharge plan may include referrals to covered services and/or appropriate community resources.

Transition of Care

The transition of care period allows an enrollee to continue a prior approved and/or active course of treatment during a transition period. Transition periods occur when there is a change in the plan’s benefit coverage, a change in a provider’s status, or during enrollment into the plan. The transition of care period is typically 60 days except in the case of maternity care, oncology treatment, or transplant services, in

which the period may be extended longer. At the close of the transition period or the course of treatment, an enrollee must transition to an in-network provider unless approved to continue services with the non-participating provider. If an enrollee requires assistance with the transition of care, a care manager can reach out and assist the enrollee to coordinate the care.

High Performing Provider Program

FCC reviews service authorization data at least annually to ensure that we only require service authorizations when necessary. Our goal in requiring service authorizations is to ensure enrollee safety while to fulfilling our fiduciary responsibility under the Medicaid contract. To that end, we use the following criteria when deciding what services to exempt from service authorization requirements for high performing providers:

- Safety of item or procedure for enrollees-- if the item or procedure has minimal risks to enrollees and is accepted in the medical community as safe or minimally invasive that a service authorization not be required.
- Frequency of request for enrollees--if a service or item is frequently requested for enrollees that a service authorization not be required.
- Percentage of time service authorization is approved--if a service authorization request for a particular item or service has a high percentage of approval that a service authorization not be required.
- Cost of item or service--low cost items or services may not require service authorization.

As a Provider Service Network Plan, Florida Community Care recognizes the administrative burden providers have when obtaining authorizations for care from various health plans. To better support our enrollees' health care needs, we are committed to decreasing the prior authorization requests for high quality providers. These include providers who demonstrate a strong understanding and application of medical necessity criteria along with achieving improved health and quality outcomes. During the first year of FCC health plan operations, FCC will review provider authorization data. High performing providers are defined as providers achieving 90% approval rates for authorizations submitted for FCC review. These providers will be offered the opportunity for waived authorizations for the services listed below. Once a provider is deemed high performing, provider utilization data will continue to be monitored for possible overutilization or underutilization of services. If any trends are noted, FCC reserves the right to request medical records and determine if the provider is providing medically necessaryservices.

The following chart identifies services that FCC will consider including in the high performing provider program:

Covered Service	**Plan Benefit**
Chemotherapy	MMA
Cochlear implants or implantation	MMA
Insulin pump	MMA
Oral or maxillofacial surgery	MMA
Advanced radiology (CT, MRI, MRA, PET scan, nuclear imaging)	MMA
Physical therapy, occupational therapy, speech therapy	MMA/LTC

Fraud, Waste, and Abuse Reporting
FCC employs a formal under and over utilization report that is presented at the QIC quarterly. Consistent reporting of under and over utilization is designed to review for potential fraud, waste, and abuse. In the Utilization Management department, fraud and abuse information detected through the course of utilization management activities is reported to the FCC Compliance Department who has the ultimate responsibility for reporting to the Agency's MPI. Additionally, FCC UM staff are encouraged to also report to the MPI via the online reporting web link at https://apps.ahca.myflorida.com/mpi-complaintform/ or by calling the Agency hotline at 1-888-419-3456.

UM Criteria

Clinical Decision Guidelines for MMA and Specified LTC Services
Licensed staff use evidence-based clinical guidelines from nationally recognized authorities in conjunction with the terms of the enrollee's benefit plan to guide utilization management decisions. Staff consult guidelines from the following sources: Florida Medicaid Coverage and Limitations Handbooks, Florida Medicaid Coverage Policies, InterQual Level of Care Guidelines (McKesson), and Aetna Clinical Policy Bulletins. The Director of Utilization Management submits the clinical guidelines annually to the Utilization Management Committee and Quality Improvement Committee for review and approval by the FCC Medical Director and participating physicians. The Director of UM also submits the guidelines to the Agency as required by contract.

InterQual Level of Care Guidelines can be accessed within the FCC Medical Management system. Aetna Clinical Policy Bulletins are public domain and be accessed electronically via https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. Florida Medicaid Coverage and Limitations Handbooks and Coverage Policies can be accessed at http://ahca.myflorida.com/medicaid/review/index.shtml.

All clinical guidelines are available upon request to providers and enrollees. Enrollees or providers can submit a request for clinical guidelines either verbally or in writing. Clinical guidelines are tools used to aid in decision-making. They are not intended to replace the clinical judgment of the licensed staff reviewing the authorization request. Licensed staff use clinical guidelines to make determinations while considering the individual needs of the enrollee as well as the local area delivery system.

LTC Service Decision Guidelines
Care managers utilize an enrollee's assessment to guide service authorizations. Care managers approve all maintenance LTC services ordered by an enrollee's physician or clinical assessor when establishing LTC plan eligibility.

When authorizing personal care services in home, care managers use an FCC proprietary tool referred to as a time tasking tool. The time tasking tool utilizes the enrollee's assessment data to generate suggested durations and frequencies of personal care hours in home. Care managers have the authority to authorize hours at or above the time tasking tool suggestion with no more than five percent variance. This helps to ensure consistency in application of the tool. If the care manager believes less hours should be authorized than are recommended, a Medical Director reviews the request.

When authorizing LTC services other than personal care, care coordinators utilize state established and published guidelines to approve services.

UM Timeliness

- Pre-service Standard Requests
  UM staff process pre-service routine requests within 7 calendar days from the date of receipt. UM staff provides electronic or written notification of the decision to providers and enrollees also within 7 calendar days from the date of receipt. All pre-service requests are treated as routine unless the provider requests otherwise.

- Pre-service Expedited Requests
  UM staff process pre-service urgent requests within 48 hours from the date and time of receipt. UM staff provides electronic or written notification of the decision to providers and enrollees also within 48 hours from the date and time of receipt. Providers can indicate a request as STAT for it to be processed urgently.

- Concurrent Review
  UM staff process concurrent requests (requests for admission or continued stay) within 24 hours from the date and time of receipt. If the request for continued stay is received less than 24 hours before the current authorization expires, UM staff process the request within 48 hours. UM staff provide electronic and written notification of the decision to providers and enrollees within 24 hours from the date and time of receipt.

- LTC Service Authorizations
  Care managers complete all authorizations for LTC services within their scope of authority within 24 hours from the enrollee's assessment.

- Retrospective Reviews
  UM staff process retrospective review requests within 30 calendar days from the date of receipt. UM staff provide electronic or written notification of the decision to providers and enrollees within 30 days from the date of receipt.

- Peer-to-Peer Reconsiderations
  UM staff notify providers of the right to request a reconsideration at the time of an adverse determination. A provider must request the peer-to-peer reconsideration within one business day of the adverse determination. The reconsideration is completed within two business days of the request either with the original physician making the determination or an alternate if the original physician is not available. If the peer-to-peer reconsideration results in an adverse determination, the UM staff follow the adverse determination process including notifying the provider of appeal rights.

- Authorization Extensions
  UM staff may request an extension to the review timeline if the extension is necessary due to matters beyond the control of FCC. This review timeline may be extended once for 4 calendar days for standard requests and 1 calendar day for expedited requests. UM staff notify the enrollee of the extension as well as the time when a decision will be made on the request.

Adverse Benefit Determinations and Appeals

Adverse Benefit Determinations

An adverse benefit determination (denial) occurs for administrative or clinical reasons. Administrative denials are denials of coverage due to contractual exclusions, benefit exclusions, benefit limitations, or benefit exhaustion. Administrative denials do not require a clinician to interpret any information or apply clinical judgment. Clinical denials of coverage occur when an FCC Medical Director determines the available clinical information does not meet criteria for coverage. FCC Medical Directors are licensed physicians, and only an FCC Medical Director may issue a clinical adverse benefit determination.

When FCC UM staff do not have sufficient information to conduct a review or render a medical necessity determination, staff issue an administrative denial of coverage for lack of clinical information. FCC UM staff must request the clinical information no less than three times prior to issuing the denial. For a pre- service standard request, the requests for clinical information must be made within seven (7) calendar days. For a pre-service expedited request, the requests for clinical information must be made within 48 hours. For a retrospective review request, the requests for clinical must be made within 30 calendar days. FCC may review the request for services and reverse the administrative denial if the clinical information is received within three (3) calendar days after the close of the authorization time period.

Notice of Adverse Benefit Determination

FCC issues written notices of adverse benefit determinations (non-certification) to the enrollee and requesting provider/facility. The notice includes the following items:

- The principal reason for the determination to deny coverage.
- Reference to the benefit provision, guideline, protocol or criterion on which the decision is based
- The clinical rationale used to make the determination.
- Instructions on how to request a copy of the UM criteria used.
- Instructions on how to initiate an appeal including the following information:
    - An explanation of the appeal process including enrollees' right to representation
    - Appeal timeframes
    - Description of appeal rights including the right to submit written comments, documents, or other relevant information to the appeal.
    - Description of the expedited appeal process for urgent denials

FCC gives the enrollee written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. FCC provides the enrollee with a written notice of adverse benefit determination for any service authorization decisions, using the template provided by the Agency (42 CFR 438.10(c)(4)(ii); 42 CFR 438.404(b); 42 CFR 438.402(b)-(c)). FCC includes an identifying number on each notice of adverse benefit determination in a manner prescribed by the Agency.

FCC UM staff mail the notice of adverse benefit determination as follows:

- For termination, suspension or reduction of previously authorized Medicaid covered services no later than ten (10) days before the adverse benefit determination is to take effect. (42 CFR 438.404(c)(1); 42 CFR 431.211) Certain exceptions apply under 42 CFR 431.213 and 214;

- By the date of the action when any of the following occur:
  - The enrollee has died.
  - The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result.
  - The enrollee has been admitted to an institution where he or she is ineligible under the Managed Care Plan for further services.
  - The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address.
  - The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
  - The enrollee's physician prescribes a change in the level of medical care.
  - The notice involves an adverse benefit determination with regard to PASSR under s.1919(e)(7) of the Social Security Act.
  - The enrollee's nursing facility has made a determination to transfer or discharge the enrollee.

    (42 FR 438.404(c)(1); 42 CFR 431.213; 42 CFR 431.231(d); s. 1919(e)(7) of the Social Security Act).
- For denial of payment, at the time of any adverse benefit determination affecting the 71-; (42 CFR 438.404(c)(2)).
- For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.

Appeal Process

FCC permits an enrollee, an enrollee's authorized representative, or a provider acting on behalf of an enrollee to appeal coverage decisions. The denial notice provides instructions on how to file an appeal including the toll-free number to reach FCC to request an appeal. An enrollee, the enrollee's authorized representative, or a provider acting on behalf of an enrollee may also request an expedited appeal when a delay in the decision may seriously jeopardize the enrollee's health or life. If the request for an expedited appeal is denied, Appeal staff notify the enrollee and/or requestor that the appeal will be processed in standard timeframes. A standard appeal is processed within 30 days from the date a written request for appeal is received. An expedited appeal is processed within 48 hours from the date a written request for appeal is received.

As part of the appeals process, the enrollee, enrollee's authorized representative, or provider acting on behalf of the enrollee may submit written comments, documents, or medical records pertaining to the case for the reviewer to consider. The peer reviewer considers all documentation submitted without regard as to whether such information was submitted or considered in the initial consideration of the case.

The reviewer for an appeal is a physician not involved in the original decision nor is the reviewer a subordinate to the original reviewer. Reviewers attest, as part of the appeal process, to having a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review and having current, relevant experience and/or knowledge to render a determination for the case under review. Once the Medical Director reaches a determination on the appeal, the appeal case is processed by a member of the Appeals team. If the determination on the appeal is favorable, FCC

Appeals team notifies a member of the UM team to overturn the original denial and approve the requested service.

The Appeals staff provide notification of the appeal decision in writing to the enrollee and provider. In the case of an expedited appeal, the notice is provided verbally as soon as possible after the determination and the written notice is sent within two (2) calendar days of the determination. In the case of a standard appeal, the determination and written notice are sent within 30 days from the receipt date. The notice contains the following information:

- The result of the appeal: upheld or overturned the original determination.
- The principal reason for determination if the denial is upheld.
- The clinical rationale used when making the appeal decision if the denial is upheld.
- Reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Information about additional appeal rights, if any.
- Notice that the provider/enrollee may request a copy of the UM criteria used.
- Notice that the enrollee is entitled to receive reasonable access to and copies of all documents, upon request.
- List of titles and qualifications, including specialties, of individuals participating in the appeal review.

Appeal staff maintain records of all appeals in the FCC Medical Management system. The appeal records contain the following information:

- Name of enrollee and provider/facility.
- Copies of all correspondence from enrollee or providers regarding the appeal.
- Dates of appeal reviews, documentation of actions taken, and the final resolution.
- Minutes of appeal proceedings, if any.
- Name and credentials of the clinical peer that reviewed the case.

Emergency Services

Enrollees and providers are not required to obtain prior authorization for any emergency services to screen and stabilize an enrollee. FCC defines emergency services using the “prudent layperson” definition in compliance with the Balanced Budget Act of 1997. Accordingly, an emergency medical condition is “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction to any bodily organ or part.” FCC will not deny payment for emergency services if an FCC representative instructs the enrollee to seek emergency services.

Behavioral Health Care

Triage and Referral

FCC staff consists of licensed nurses and/or health care professionals who are available to respond to an enrollee's request for behavioral health services or respond to a crisis call that comes in through any area of the organization. If an enrollee calls Enrollee Services and presents in a crisis situation, call center staff initiate crisis call protocol, as trained. If during a request for medical services, UM staff identify a behavioral health need for the enrollee, the UM staff will refer the enrollee or provider to the FCC care manager, for appropriate assessment.

Behavioral Health UM

FCC believes strongly in providing integrated care for enrollees and as such, coordinates clinical efforts with our behavioral health providers. FCC UM staff also participates, as requested, in any behavioral health interdisciplinary team meetings.

Evaluation of New Technology

FCC is a Long-Term Care Plus health plan with a Florida Medicaid contract. As such, the Agency manages benefits and new technology determinations. FCC complies with all benefit requirements contained in the Agency contract as well as Florida Medicaid Coverage Policies or Coverage and Limitations Handbooks.

Confidentiality and Use of PHI

FCC considers protected health information (PHI) private and confidential and has policies and procedures in place to protect PHI against unlawful use and disclosure. FCC protects the privacy of PHI in accordance with federal and state privacy laws including HIPAA privacy laws. When necessary or appropriate for the care and treatment of enrollees, company operations, or to conduct related activities, FCC uses and/or discloses the minimum necessary PHI. FCC does not require an authorization from the enrollee to use or disclose PHI in the following health care operation activities:

- Treatment (coordination of care, provision of health care)
- Payment (eligibility, coordination of benefits, authorizations, claims payment)
- Operations (quality improvement activities, risk management, fraud, waste, and abuse reporting, internal auditing and monitoring)

Referral Guidelines

A referral is defined as the process of directing or redirecting (as a medical case or a patient) to a long- term care provider, an appropriate specialist or an agency.

For Florida Community Care enrollees, referrals to a participating specialist and/or ancillary location are not required. While we encourage enrollees to work with their Primary Care Physician (PCP) before seeing a specialist in order to ensure the PCP can help to coordinate care, a formal referral is not required for payment.

Clinical Practice Guideline Monitoring and Improvement

Clinical practice guidelines are used to assist practitioners and enrollees in their decisions about appropriate care for specific clinical circumstances. Florida Community Care uses national, state, or specialty recognized guidelines. Local physician committees have opportunities to make recommendations on the use of these guidelines.

Some of the clinical practice guidelines used -by the Plan include:

- The American Diabetes Association - Adult Diabetes
- The National Institute of Health - Asthma (Pediatric and Adult)
- The American College of Cardiology – Heart Failure, Coronary Artery Disease
- The Journal of the American Medical Association – Hypertension
- The American Psychiatric Association - Major Depression
- The Global Initiative for Chronic Obstructive Lung Disease – Chronic Obstructive Lung Disease
- National Institute of Mental Health – Bipolar Practice Guidelines

We select several key indicators from at least two of these clinical practice guidelines to monitor the process and outcomes of care related to these practice guidelines. This may require periodic review of the participating physician's office record.

Clinical practice guidelines are periodically reviewed and evaluated for updates and changes. Practice Guidelines are available on our website under Medical Information.

Emergency Health Care Services

Florida Community Care covers pre-hospital and hospital-based trauma services and emergency services and care to enrollees as per ss. 395.1041, 395.4045 and 401.45, F.S. When an enrollee presents at a hospital seeking emergency services and care, a physician of the hospital or other appropriate personnel under physician supervision shall make a determination that emergency medical condition exists for the purposes of treatment. Refer to ss.409.9128, 409.901, and 641.513 F.S. for more details.

Florida Community Care will not deny claims for emergency services and care received at a hospital due to lack of parental consent. FCC will not deny payment for treatment obtained when a representative of FCC instructs enrollee to seek emergency services and care in accordance with s. 743.064, F.S.

Florida Community Care will cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency until such time as the enrollee can be safely transported to a participating facility. FCC may transfer the enrollee once considered stable and able to a participating hospital that has service capability to treat enrollee's emergency medical condition.

Florida Community Care, in accordance with 42 CFR 438.114 and s.1932(b)(2)(A)(ii) of Social Security Act, will cover post-stabilization care services without authorization, whether services were provided from a nonparticipating or participating physician. Any post-stabilization services a treating physician deems is medically necessary is considered non-emergent. Florida Community Care reserves the right to deny coverage of non-emergency services provided by non-participating providers, except in the following circumstances:

- Pre-approved post-stabilization care services;
- Post-stabilization care services performed wherein said provider requested pre-approval and Florida Community Care failed to respond within an hour of the request being made; and
- Post-stabilization care services performed wherein treating physician was unable to contact Florida Community Care.

Florida Community Care will authorize payment for non-participating physicians for emergency ancillary services provided in a hospital setting. FCC shall ensure the enrollee has a follow-up visit scheduled within seven (7) days after discharge

Florida Community Care shall ensure that enrollee receiving emergency care will have authorized prescriptions at the time of discharge.

Florida Community Care also covers emergency behavioral health services pursuant, but not limited to s. 394.463, F.S.; s. 641.513, F.S.; and Title 42 CFR Chapter IV.

Behavioral emergency service providers shall make a reasonable attempt to notify FCC within twenty- four (24) hours of enrollee's presenting for emergency behavioral health services. In cases in which the enrollee has no identification or is unable to identify him/herself orally when presenting for behavioral health services, the provider shall notify FCC within twenty-four (24) hours of learning enrollee's identity.

Claims Processing and Payment Guidelines

This section explains certain aspects of the claim process. For a more in-depth outline, please refer to our website at www.fcchealthplan.com.

Refer to the Payment Policies on the Florida Community Care website for information on payment methodologies, payment rules, and how the Plan applies those rules to your claim.

Type of Claims Submissions

Paper Claims

Instructions for completing the CMS-1500 and UB-04 claim forms can be obtained from the following websites:

- Centers for Medicare & Medicaid Services *www.cms.gov*
- Florida Hospital Association *www.fha.org*
- National Uniform Billing Committee *www.nubc.org*
- National Uniform Claim Committee *www.nucc.org*
- Florida Community Care Electronic Transaction Guide

Paper claims should be mailed to:

Florida Community Care
Attn: Claims
PO Box 211322
Eagan, MN 55121

Electronic Claims

Electronic Claim Submissions allow providers to safely submit and track HIPAA-compliant electronic claims to us via Availity without manual intervention.

Electronic claims may be filed through Availity or send your claims through a billing service or clearinghouse to transmit to Availity and then route to us. Availity edits transactions according to the HIPAA-AS requirements. A number of payer-specific edits are also performed before routing transactions to Florida Community Care.

Additionally, Ability is also available for providers to transmit claims into Florida Community Care (FCC). Ability can provide easy to use forms configured for non-traditional services which Florida Community Care provides throughout its network of providers. Ability will connect all transactions with standard payer services with FCC to transmit invoices and transactions with FCC.

If a claim transaction fails either the HIPAA-AS or our edits, Availity will not forward the claim to us for payment. Provider receives standard messaging on their Availity electronic batch report (EBR) and can review it before resubmitting claims.

Visit the Provider Portal through our FCC website at www.fcchealthplan.com for additional electronic transmission support information.

Prompt Claims Processing/Timely Filing Limits

Providers must file claims within the time set forth in their Florida Community Care participating provider Agreement(s) unless applicable law requires a greater time period for filing of claims. If applicable to a particular benefit agreement, current Florida law and other legal requirements provide that claims must be filed within 180 days after the date of service and receipt by the provider of the name and address of a patient's health insurer.

Provider should submit claims indicating their usual fees for services rendered. Florida Community Care will make appropriate adjustments based on the contractual agreement. We comply with applicable legislation regarding timeliness of filing and processing claims.

Claims and Encounter Data Submissions

A critical element in claims filing is the submission of current and accurate codes to reflect the services provided. For proper payment and application of coordination of benefits, it is important to accurately code all diagnoses and services in accordance with national coding guidelines.

Inclusion of a complete and accurate list of diagnosis codes associated with the enrollee at the time of the encounter, including any chronic conditions not necessarily treated at the time of the encounter, will help ensure correct coding of the encounter. Additionally, it helps us match patients with appropriate care and disease management programs, and ensure enrollees are properly classified by risk programs. We encourage you to purchase current copies of CPT, HCPCS, and ICD-10-CM codebooks.

It is particularly important to accurately code your claim because the level of coverage may vary under the enrollee's benefit plan for different services. You must submit a claim and/or encounter, regardless of whether you have collected the enrollee's copayment, deductible or coinsurance at the time of service.

To prevent claims processing and payment delays, follow the claims filing hints below:

- Verify coverage. Enrollees can have changes in their health insurance benefit plans or eligibility. You should always verify coverage through our Provider Portal which can be accessed via our website at www.fcchealthplan.com.Submit the entire enrollee ID number. Submit the enrollee ID number, not the enrollee's Social Security number. The 835 electronic remittance advice will indicate when an enrollee's identification (ID) number is processed with a different identifier than was submitted.
- Complete all claim entry fields. To receive proper reimbursement, the claim information must be completed in its entirety. Incomplete or inaccurate information will result in a claim denial.
- Enter the date of onset, if applicable. All ICD diagnosis codes in the 800-900 range require a date of onset (injury, accident, first symptom, etc.).
- Use valid codes. CPT, HCPCS, and ICD codes are updated quarterly. Make sure you or your billing service is using the most up-to-date codes.
- Report an unlisted code only if unable to find a procedure code that closely relates to or accurately describes the service performed. Unlisted codes require documentation and therefore cannot be submitted electronically.
- Use diagnosis codes that indicate a general medical exam when billing for "preventive" health screening exams. Claims for these services will be denied if other diagnosis codes are used.

- Submit modifiers affecting reimbursement in the first and second position on claims. A procedure code modifier, when applicable, provides important additional information about the service performed. When multiple modifiers are necessary for a single claim line, modifiers should be submitted in the order that they affect payment.
- Submit multiple procedures on one claim. All procedures performed on the same date of service, by the same provider for the same patient should be submitted on one claim.
- Submit all applicable diagnosis codes. Code to the highest level of specificity possible. Most 3-digit codes require a fourth or fifth digit.
- Include the National Provider Identifier (NPI) for rendering physician and billing physician or group. Both the CMS-1500 and UB-04 include fields for the NPI.

CMS-1500:

- Block 24J is for Type 1 NPIs (Rendering Physician)
- Block 32A is for Type 2 NPIs (Service Facility)
- Block 33 A is for Type 1 or 2 NPIs (Billing Physician/Group)

The above blocks are split to allow your Florida Community Care provider number in the shaded area and your NPI in the non-shaded area labeled NPI.

UB-04:

- Field 56 is for the NPI of the Billing Facility/Provider
- Field 76 is for Type 1 NPIs (Attending Provider)
- Field 78 and 79 are for Type 1 NPIs (Other referring provider)
- Use the correct Tax ID or Social Security number. For participating providers, the Tax ID Number (TIN) reported on the claim should match the TIN found within the provider agreement, which is the provider/legal entity's payee TIN. Should your legal entity TIN change, please contact your Florida Community Care Network Manager directly before claims are submitted containing the new information
- When services are rendered in a facility that is NOT associated with the billing entity, enter name and address along with NPI if available.
- Valid 9-digit zip codes are required.
- Submit the correct billing provider information.
- Individual Physicians/Providers: Enter the name, address, phone number, and NPI of the individual physician, if services were rendered in a solo practice.
- Groups: Enter the name, address, phone number and NPI of the group practice
- Valid 9-digit zip codes are required.

Note: *Billing provider address is the location where services were rendered and MUST be a street address. If the payment address is different than the billing address, submit in the "Pay To" including any P.O. Box.*

- **Duplicate Claims** Avoid sending duplicate claims. For claims status, use our Provider Portal which can be accessed via our website at www.fcchealthplan.com. or contact 1-833-FCC-PLAN, Option

2. If filing electronically, be sure to also check your clearinghouse file acknowledgment and EBR for claim level failures. Allow 15-days for electronic claims and 30-days for paper claims before resubmitting.

- **Corrected claims.** Please follow the instructions under “Corrected Claims” below to ensure accurate information is provided and processed correctly.
- **Taxonomy Code.** Claims should contain the proper provider taxonomy code, especially for MA Enrollees.
- NPI and Sub-Part Identifiers. Claims should also contain the proper NPI for sub-units of a hospital, if applicable, especially for MA enrollees or if the sub-unit is a participating with Florida Community Care. If a NPI was not obtained for sub-units of the hospital, ensure the proper taxonomy code is used when billing -the Plan.

You can learn more about the many tools available to help you prepare, submit and manage your Florida Community Care claims by accessing the Florida Community Care web site.

Note: *To order CMS-1500 and CMS-1450 (also known as UB-04) forms, contact the U.S. Government Printing Office at (202) 512-0455, or visit their website at cms.hhs.gov.*

Medical Records Review for Claims Payment

Under certain circumstances, Florida Community Care will suspend claims for medical review in order to determine if the services rendered are covered. Clinical information/medical records for these select procedures/services may be requested to support claims adjudication. Failure to submit the clinical information/medical records may result in processing and payment delays.

Clinical documentation/medical records that may be requested include, but are not limited to the following:

- History and physical
- Operative reports
- Physician/nurse notes
- Consultation reports
- Lab reports
- Radiology reports
- Anesthesia notes and time
- Physician orders
- Plan of treatment
- Medication name, physician order, dosage, units, and NDC number

Requesting Medical Records (Claims Payment Use)

When additional documentation is required to process a claim Florida Community Care will fax or mail a written request to you. The request will include a letter and a routing sheet for a specific claim. The letter contains the key data from the claim (i.e., patient name, enrollee number, patient account number, and claim number), information requested, and the reason additional information is needed. This routing sheet serves as the fax cover sheet or cover page for documents that are mailed back to – Florida Community Care and is used for tracking purposes. The following are tips for submitting claim documentation when it is requested:

- The Routing Sheet must be only used for the matching documentation. Do not copy the Routing Sheet for multiple claims. It is for a specific claim and enrollee.
- The Routing Sheet must always be the top sheet attached to the documentation regardless of the mode of return (i.e., fax, mail).
- When the documentation is returned by fax, the Routing Sheet must be fed from the top of the page to the bottom of the page.
- Do not attach separate sets together. Fax one information package at a time. Our electronic receiving system only recognizes the first page as the Routing Sheet and catalogs all subsequent pages accordingly.
- Do not write on the Routing Sheet except to place an “X” within the applicable boxes to designate what type of documentation is attached to the Routing Sheet.
- Should records contain greater than 100 pages, they must be packaged with the Routing Sheet as the first page. mail the documentation to:

  Florida Community Care

  Attn: Claims - Medical Records

  PO Box 261090

  Miami, FL 33126

- Do not send double-sided copies.
- Do not return the original letter that was sent with the Routing Sheet.

Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed.

Claims returned requesting additional information or documentation should not be submitted as corrected claims. While these claims have been processed, additional information is needed to finalize payment.

Note: *We do not consider a corrected claim to be an appeal.*

- Corrected claims, whether electronic or via paper require the appropriate bill or frequency type codes listed below. They can then be included in your normal electronic submission process (e.g., HIS, PMS). Contact your vendor if you need assistance identifying the loop and segment for the type codes.
- For institutional claims, use the three-digit Bill Type (XX7 or XX8) ending in the appropriate number. For professional claims, use the appropriate number (7 or 8) for the Frequency Type.

  7 – Replacement of Prior Claim - If you have omitted charges or changed claim information (diagnosis codes, dates of service, enrollee information, etc.), resubmit the entire claim, including all previous information and any corrected or additional information.

  8 – Void/Cancel of Prior Claim - If you have submitted a claim to Florida Community Care in error, resubmit the entire claim. If the claim was paid, resubmit the claim to – Florida Community Care using the Claim Overpayment Refund Form.

Claim Status/Inquiry

Providers may submit claim status inquiries for a variety of reasons (e.g., corrected claims, late charges, medical records, etc.). When submitting a claim inquiry, complete the Provider Reconsideration/Administrative Appeal Form and attach it to your claim. A wide range of self- service options are available through the Provider Portal at www.fcchealthplan.com to enable providers to view a summary of claims that have previously been paid, rejected or pended. Please refer to the Frequently Referenced Self Service Section for additional information on the self-service tools.

Rejected Claims

All paper claims go through “front-end” edits that verify eligibility information. Claims that cannot be scanned by Optical Character Recognition (OCR) will be returned to the provider with an accompanying explanation. If the claim is returned, it must be submitted as a new claim; not a “corrected” claim. Returned claims are rejected prior to processing; therefore, there is not an original claim to correct in the system.

Pharmacy Claim (Medical Claim)

Submit claims for payment directly to Florida Community Care following the guidelines below.

Drug Units

The drug units must always be included on the claim submission. The drug units should be based on the HCPCS code, not the NDC, unless a specific J code is not assigned to the drug.

Unclassified drug codes (J3490, J3590, J9999, J1599, etc.) must always be billed with the drug name, NDC and NDC units. The NDC should be provided in field 24G on a CMS-1500 and in loop 2410 segment LIN on an electronic 837 Professional claims submissions. If you have additional questions on how to bill NDCs for electronic claim submission, please refer to NDC Quantity section within Coding a Professional Claim within the Provider Handbook and/ or contact your software Management Company or clearinghouse. Failure to provide this information may delay claim processing.

Diagnosis

Include the primary diagnosis code on the claim, which is the reason for the drug use.

Claims submitted with only a V58.1 diagnosis code (Other and Unspecified After-Care Maintenance Chemotherapy) will require additional information prior to a coverage decision.

Modifiers

The JW modifier is a Health Care Common Procedure Coding System (HCPCS) Level II modifier used on a Medicare Part B drug claim to report the amount of drug or **biological** (hereafter referred to as drug) that is discarded and eligible for payment under the discarded drug policy.

When billing the JW modifier, the claim line with the discarded quantity amount should only be identified. At this time, the JW modifier is not required but accepted in order to identify the quantity being reported as drug wastage.

Claims should be submitted electronically through Availity or a clearinghouse. Medical Policies (Medical Coverage Guidelines) used for pre- and post-service review related to the specified drugs are available on Florida Community Care website.

If you have additional questions or need to verify your current contractual agreements, contact Network Management.

HIPAA Version 5010 Updates and Helpful Tips

Below are updates and helpful tips for processing your Version 5010 claims to avoid unnecessary rejections:

- **National Provider Identifier (NPI):** Previously, you were allowed to report an Employer's Identification Number (Tax ID) or Social Security Number (SSN) as a primary identifier for the billing provider. For Version 5010 claims, you are only allowed to report an NPI as a primary identifier.
- Before using your NPI to file claims, you must register it with Florida Community Care. Simply complete and return the NPI Notification Form.

Note: *For more specific information on how to bill, please refer to the below items:*

- **Billing Provider Address:** You must use a physical street address for your Billing Provider Address. Version 5010 does not allow for use of a P.O. Box address for either professional or institutional claim formats. You can still report a P.O. Box as a pay-to address.
- **ZIP Code:** You need to include a complete 9-digit ZIP code for the billing provider and service facility location. You should work with your software vendor or clearinghouse to make sure that your system captures the full 9-digit ZIP code.
- Taxonomy and NPI are now required fields.
- **Present on Admission (POA) Indicator:** A POA indicator is now submitted in conjunction with diagnosis codes.
- **Ambulance Services (pick-up/drop off):** A valid postal zone or zip code is required when billing for ambulance or non-emergency transportation services.
- **Anesthesia Services:** Minutes are required for anesthesia claims.
- **Coordination of Benefits (COB):**
    - The Other Payer allowed amount can no longer be reported for electronic claims.
    - The Rules of Balancing now include the COB section of the claim.
- **First Name**: First name is not required when this information is not available/not known.
- **Outpatient Claims:** Outpatient claims now require a new segment “Patients Reason for Visit”.

Claim Payments and Statements

Remittance Advice

The remittance advice provides you with claim payment and rejects information. When you file a claim, you can view your remit online using the Availity Remittance Viewer. If a payment is due, you will receive payment by check or Electronic Funds Transfer EFT.

Claims are processed daily and combined into a weekly payment. Remittance advice are also generated on a weekly basis. Providers receiving payments via EFT may view the electronic remittance on Availity portal. Providers that elect to be paid by Paper check will receive payments and hard copy of the remittance advice at the provider's payment to location for the claim.

Capitation is paid once a month (by the 15th of the month). These dates are subject to change.

If you file electronically, you can receive the 835 ERA upon request. Refer to the Health Care Payment/Advice section for additional information on how to start receiving the 835.

Overpayment Recovery

For claims subject to Florida law, refer to Florida Statutes Sections 627.6131 and 641.3155.

An overpayment is reimbursement in excess of the monetary obligation that we have with respect to a particular claim. Florida Community Care pursues timely recovery of all identified overpayments using various methods.

Offsetting Policy

We use a payment offsetting policy to recover claim overpayments. We recover the overpaid amount by offsetting (deducting) it from current or future claim payment(s). In other words, the overpaid amount is subtracted from the payment for claims on a subsequent remittance.

Before offsetting, if applicable, we follow state law, which requires advance notification of the intent to recover overpayments through an offsetting process. According to their Agreement with us, participating providers are required to promptly notify -the Plan of claims processing or payment errors and allow for the use of offsetting/recouping overpayments.

Timeframe for Requesting Overpayments

For claims subject to Florida law, refer to Florida Statutes Sections 627.6131 and 641.3155.

Overpayment Policy

Plan Identified Overpayments

All refunds of overpayments in response to overpayment requests received from us or one of our contracted vendors should be sent to the name and address of the entity outlined on the refund request letter. Please include appropriate documentation that outlines the overpayment, including customer's name, health care ID number, date of service and amount paid. If possible, please include a copy of the remittance advice that corresponds with the payment from us. If the refund due is a result of coordination of benefits with another carrier, provide a copy of the other carrier's EOB with the refund.

When we determine that a claim was paid incorrectly, we may make claim adjustments without requesting additional information from participating health care providers. In the case of an overpayment, we will request a refund at least 30 calendar days prior to implementing a claim adjustment, or as provided by applicable law. You will see the adjustment on the EOB or RA. When additional or correct information is needed, we will ask you to provide it.

We provide advance notification of the intent to recover overpayments by sending a refund request letter. Information contained in the letter includes:

- Claim(s) that were overpaid
- Overpayment reason
- Overpayment amount
- Corresponding enrollee information

Actions to complete upon receipt of the refund request letter

1. Review the letter for the appropriate request reason and claim data.
2. Contact the Provider Contact Center if additional basic information is needed to process the refund.
3. Submit a refund within 40-days.
4. At a minimum, clearly notate the following information associated with the refund payment:
    - Enrollee ID number
    - Claim number
    - Date of service
    - Patient name
    - Patient account number
    - Invoice number (preferred)
5. Notify us in writing, within 35-days of letter receipt, if the overpayment request is being contested or denied. Clearly notate the contested or denied portion of the claim overpayment request and provide the specific reasoning.

Provider Identified Overpayments

If you identify a claim for which you were overpaid, you must send the overpayment within 30 calendar days from the date of your identification of the overpayment. If overpaid funds are not returned in a timely the manner, the plan may request repayment. If we do not receive repayment within 45 days of our written request, the plan may take action to recover overpayment, to the extent permitted by applicable law, including but not limited to, by offsetting against futureclaim payments.

Providers may choose to handle repayments in any of the following two ways:

Option 1: Contact the Provider Contact Center

- Call the Provider Contact Center to request a refund letter.
- Submit a corrected claim if the original claim data is beingchanged.
- Upon receipt of the refund letter, follow the steps outlined in the above Florida Community Care Identified Overpayments section.

Option 2: Refund the overpayment

When an overpayment applies to only one or some of the claims associated with a check:

- Cash the check and issue a personal/company check to us for the overpaid amount.
- Resubmit your claim in accordance with Void/Cancel of Prior Claim processes outlined above
- Send the issued check and any other documentation such as corrected claim, remittance advice, and other carrier's explanation of benefits with affected claims circled.

Overpayment applies to all claims

When an overpayment applies to all claims associated with a check:

- Return the plan issuedcheck
- Mail a check and any supporting documentation such as corrected claim, remittance advice to:

Florida Community Care Attn:

Claims - Overpayment PO Box

5607

Hauppauge, NY 11788

Provider Complaints, Appeals and Dispute Resolution

FCC maintains effective and proven procedures for handling provider inquiries, complaints and disputes, including receipt and tracking methods of escalation processes and resolution timeframe requirement as well as follow-up responsibilities. Provider Disputes will be resolved as described in s 408.757, F.S.

Provider Complaints

Providers submitting complaints concerning non-claim issues shall have (45) days to file their written complaint. FCC will notify providers within (3) days of filing a complaint that complaint has been received and will provide to the provider an expected date of resolution. FCC will contact the provider verbally or in writing. A written notice of status will be provided to the provider every (15) days thereafter until the Complaint is resolved. FCC will resolve all non-claims provider complaints within (90) days of its receipt and will provide written notice of the disposition to the provider within (3) business days of resolution, including the basis of the resolution.

For provider complaints concerning claims issues, providers shall have ninety (90) days from the date of final determination of the primary payer to file a written complaint. FCC will notify providers within (3) days of filing a complaint that complaint has been received and will provide to the provider an expected date of resolution. FCC will contact provider verbally or in writing. A written notice of status will be provided to the provider within (15) days of the claim complaint. For issues that require additional time to research, FCC will submit a written request for extension to the Agency within three (3) business days of receipt of the complaint. FCC will provide written notice of the status of the complaint to the Agency and the provider every fifteen (15) days thereafter. FCC will resolve all claims-related provider complaints within (60) days of receiving the complaint and will provide written notice of the disposition and the basis of the resolution within three (3) business days of resolution.

Providers can contact FCC using any of the methods below:

- In person through your Provider Relations Representative
- Via phone call to the Provider Call Center: 1-833-FCC-PLAN, Option 2
- Email through our provider self-service website: www.fcchealthplan.com
- In writing via U.S. mail to:

  Florida Community Care
  Attn: Provider Complaints
  PO Box 261060
  Miami, FL 33126

Our Provider Call Center team offers an increased level of service for our network providers. Providers can call a toll-free number to interact with a Provider Services Representative, who can immediately assist with inquiries related to claims payment and other issues. Florida Community Care's goal is first- call resolution for all provider inquiries. The list below is an example of some inquiries that can be resolved through first-call resolutions:

- Claims denied incorrectly
- System generated denials where the system is now updated
- Incorrect no-authorization denials
- Coordination of benefit denials where the system now shows the correction

- Enrollee-not-covered denials when the enrollee shows as eligible
- Configured-rate-amount errors where the system was updated
- Incorrect Provider

Provider Disputes

Providers may request reconsideration of how a claim processed, paid or denied. These requests are referred to as disputes. Florida Community Care has a defined Provider Dispute Resolution process for use by providers who are dissatisfied with how a claim processed, paid or denied.

If a provider would like Florida Community Care to reconsider a claim adjudication decision, providers may submit reconsiderations for a variety of reasons (e.g., claim allowance, coordination of benefits, provider contract issue, etc.). When submitting a claim Reconsideration, provide a written statement of the dispute, along with the following information:

- The completed Provider Dispute Form
- A written explanation supporting the claims appealed
- A copy of the remittance advice attached
- The necessary medical documentation (e.g., operative report, physician orders, history and physical) as indicated by the reason for the reduction or the denial on the remittance advice
- Documentation from a recognized authoritative source that supports your position on the procedure codes submitted (optional)

Send Reconsiderations/Appeals to
Florida Community Care
Attn: Provider Disputes PO
Box 261060
Miami, FL 33126

For more information on Provider Dispute Resolutions, please contact your Provider Relations Representative.

AHCA Dispute Resolution Program

If the Provider has submitted a reconsideration request and is not satisfied with the decision received by letter, the provider can access AHCA's contracted disputed resolution program*. AHCA has* contracted with MAXIMUS, an independent dispute resolution organization, to provide assistance to health care providers and health plans in order to resolve claim disputes. MAXIMUS has been accepting claim disputes for Florida's managed care line of business since May 1, 2001. Services offered by Maximus are available to Medicaid managed care providers and health plans. Claims submitted to managed care plans that have been denied in full or in part, or allegedly underpaid or overpaid may be eligible for dispute under the arbitration process. Application forms and instructions on how to file claims disputes can be obtained directly from MAXIMUS by calling **1-866-763-6395 (select 1 for English or 2 for Spanish), and then select Option 2 -** Ask for Florida Provider Appeals Process.

Medical Records Guidelines

Enrollee Medical Records Requirements

All providers rendering service to Florida Medicaid recipients must follow the enrollee record standards set forth in Rule 59G-1.054, F.A.C. Florida Community Care will periodically audit enrollee records to ensure compliance with the rule as outlined below and to determine whether Florida Medicaid payment amounts were, or are, due.

1. Documentation Requirements.
    (a) All Florida Medicaid providers must:
        1. Ensure medical records establish the medical necessity for and the extent of services provided.
        2. Sign and date each medical record within two business days from the date and time of service, or otherwise authenticate the record by signature, written initials, or computer entry. Electronic signatures are permissible as defined in Chapter 668, Part I, F.S.
        3. Initial rubber-stamped signatures.

    (b) Unless otherwise specified in Florida Medicaid coverage policies, providers must document the following information for each service visit or encounter with a Florida Medicaid recipient:
        1. Chief complaint of the visit.
        2. Date(s) of service.
        3. Description of services rendered (as applicable).
        4. Diagnosis.
        5. Diagnostic tests and results (as applicable).
        6. History and physical assessment (as applicable).
        7. Prescribed or provided medications and supplies (as applicable).
        8. Progress reports.
        9. Referrals to other services (as applicable).
        10. Scheduling frequency for follow-up or other services (as applicable).
        11. Treatment plan (as applicable).
2. Electronic Records.
    (a) Providers that create or maintain electronic records must develop and implement an electronic records policy to comply with the applicable state and federal laws, rules, and regulations to ensure the validity and security of electronic records. Electronic record policies must address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.
    (b) Providers that maintain electronic records must have the ability to produce electronic records in a paper format within a reasonable time, upon AHCA's or Florida Community Care's request.
3. Recordkeeping Requirements. Providers must retain all business records, medical-related records, and medical records, as defined in Rule 59G-1.010, F.A.C., according to the

requirements specified below, as applicable:

(a) Providers may maintain records on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or Florida Medicaid requirements. All records must be accessible, legible, and comprehensible.

(b) Providers must retain all records related to services rendered to Florida Medicaid recipients for a period of at least five years from the date of service. Medicare crossover-only providers must retain health care service records for six years or as outlined in your Provider Agreement with Independent Living Systems/Florida Community Care.

4. Copying or Transferring Records.

   (a) Providers may seek reimbursement from a recipient for copying medical records at the recipient's request when the provider's standard policy is to bill all patients for copying medical records and the recipient is notified of the copying charge before the records are copied.

   (b) Providers may not seek reimbursement from the recipient or AHCA for copying records requested by AHCA or any other state or federal agency or their authorized representatives.

5. Right to Review Records.

   (a) Authorized state and federal agencies, and their authorized representatives, may audit or examine provider records. This examination includes all records these agencies find necessary to determine whether Florida Medicaid payment amounts were, or are, due. This requirement applies to the provider's records and records for which the provider is the custodian. Providers must give authorized state and federal agencies, and their authorized representatives, access to all Florida Medicaid recipient records and any other information that cannot be separated from Florida Medicaid-related records.

   (b) Providers must send, at their expense, legible copies of all Florida Medicaid-related information to the authorized state and federal agencies or their authorized representatives upon their request.

   (c) All records must be provided regardless of the media format on which the original records are retained by the provider at the time of the request. All medical records may be reproduced electronically or onto paper copies as authorized by the requestor.

Confidentiality of Enrollee Information

Confidentiality and accuracy of an enrollee's record must be maintained at all times. Florida Community Care requires that all providers comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of enrollee data. The privacy of any information that identifies a particular enrollee must be safeguarded. Information from or copies of an enrollee's record may only be released to authorized individuals.

Providers must take steps to prevent unauthorized individuals from gaining access to or altering an enrollee's record. Original records may only be released in accordance with state laws, court orders or subpoenas, and timely access by enrollees to the information that pertains to them must be ensured. Additionally, Florida Community Care and providers must abide by all federal and state laws regarding confidentiality and disclosure of all enrollee records and information.

All health care professionals who have access to medical records have a legal and ethical obligation to protect the confidentiality of enrollee information. In order to fulfill these obligations, the following guidelines have been developed:

- By Federal Statute, all individuals and institutions with access to PHI must comply with the HIPAA Privacy Final Rule.
- All health care professionals and employed staff who have access to enrollee records or confidential enrollee information should be made aware of their legal, ethical and moral obligation regarding enrollee confidentiality and may be required to sign a document to that effect.
- Enrollee records should be accessed only by authorized staff; should not be left in public view and should be stored in an organized and consistent manner.
- Enrollees have the right to access their medical records according to Florida Community Care rules and in accordance with applicable law.
- Any and all discussions relating to confidential enrollee information by staff should be confidential and conducted in an area separate from enrollee treatment or waiting areas.
- Safeguards to maintain the confidentiality of faxed medical information should be in place.
- Primary and specialty physicians and their staff are to receive periodic training regarding protection of confidentiality of patient records and the release of records.
- In the event enrollee records are to be sent to another provider, a copy of the signed authorization for the release of information should be enclosed with the records to be sent. The records should be sent in an envelope marked “Confidential”.
- A copy of the policy on confidentiality of medical records may be posted in the provider’s office.

If the enrollee is present and has the capacity to make health care decisions, providers may only communicate with a patient’s family enrollees, friends, or other persons if the enrollee consents (45 CFR 164.510(b). The provider may request the enrollee’s permission to share relevant information with family enrollees or others, may tell the patient he or she plans to discuss the information and give them an opportunity to agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object.

If the enrollee is not present or is incapacitated, the provider may share the patient’s information with others involved in their care or payment for care, if they have written of consent from the enrollee or, if the provider determines, based on professional judgment, that doing so is in the best interests of the patient.

In all cases, disclosures must be limited to only the protected health information directly relevant to the individual’s involvement in the patient’s care or payment for care.

In all cases psychotherapy notes are private and may not be disclosed without the enrollee’s consent, including disclosure to a health care provider other than the originator even in cases where the disclosure

is for treatment purposes. Exceptions for disclosures required for law enforcement, such as for mandatory reporting of abuse, and mandatory “duty to warn” situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible.

Florida Community Care, AHCA, and any federal or state agency, and their designees, must have access to enrollee records.

Enrollee Information and Resources

Enrollee Rights and Responsibilities

As a recipient of Medicaid and an enrollee the Florida Community Care Plan, our members have the following rights:

- Be treated with courtesy and respect
- Have your dignity and privacy respected at all times
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- Be given information about your diagnosis, the treatment you need, choices of treatments, risks, and how these treatments will help you
- Say no any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can't make them yourself (advanced directive)
- To file a grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive services in a home-like environment regardless of where you live
- Receive information about being involved in your community, setting personal goals and how you can participate in that process

- Be told where, when and how to get the services you need
- To be able to take part in decisions about your health care.
- To talk openly about the treatment options for your conditions, regardless of cost or benefit
- To choose the programs you participate in and the providers that give you care

As a recipient of Medicaid and an enrollee of the Florida Community Care plan, our members have the following responsibilities:

- Give accurate information about your health to your Plan and providers
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions and ask questions
- Keep your appointments or notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary, for your safety
- Report fraud, abuse, and overpayment
- Tell your case manager if you want to dis-enroll from the Long-term Care program
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager

Disease Management Program

FCC offers our Disease Management program services through a team of specialized staff and health professionals with clinical experience assisting enrollees who live with a chronic illness. Condition- specific interventions and programs focus on improvement of specific clinical conditions and promote continuous quality improvement for our enrollees. Providers are encouraged to collaborate with us in an effort to close gaps in clinical care. This can be accomplished by referring enrollees with chronic conditions into our Disease Management Programs, where they will receive condition-specific coaching and education related to their condition.

Our Disease Management Programs include the following conditions:

- Cancer
- Diabetes
- Asthma and Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Mental/Behavioral Health

- Dementia
- Alzheimer's

Our interdisciplinary care team develops our condition-specific disease management programs with strengths in the following areas:

- Clinical;
- Information technology;
- Call center;
- Community Health Workers;
- Nutritionists and Social Workers

FCC case managers work with the enrollee in collaboration with any third-party health plans the enrollee may also be a member of, providers and support systems, to optimize our disease management intervention by leveraging all resources available to the enrollee.

FCC provides interventions which range from educational information for both the provider and enrollees to disease management training from our case managers to better empower enrollees. Enrollees will receive different levels of interventions identified by the disease risk level or need.

Core components of Disease Management Programs include collaboration between PCP, behavioral health provider (when applicable) and specialty providers and is essential to maintain and provide both the appropriate level of care and continuity of care. Our case managers act as a health navigator and liaison for the enrollee working in collaboration with the PCPs and specialty providers to ensure that there is open communication, education, preventative care and appropriate care and treatment for the enrollee. Each covered disease has its own individualized program specific to the characteristics and treatment plan(s) for that disease. More information on these programs can be found on our website at www.fcchealthplan.com.

FCC conducts interdisciplinary care team meetings which involve multiple disciplines from our care team, the enrollee, their caregiver or family support, other service providers or community organizations, additional case managers involved, the PCP and specialty provider(s). We discuss the enrollee's care during the interdisciplinary care team meeting along with identifying personal goals and interventions to achieve enrollee-centric outcomes.

FCC believes that a well-integrated disease management program will improve health outcomes. We evaluate our performance measures yearly.

Healthy Behaviors Programs

FCC offers Healthy Behaviors Programs for enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance use disorder in order to establish written agreements to secure the enrollees' commitment to participation in these programs. These programs will comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG).

Our Healthy Behaviors Programs include the following conditions:

Smoking Cessation Program

As part of our Smoking Cessation Program, our provider relations team will provide education to participating PCPs regarding the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions.

Enrollees will be identified through annual PCP screening and our care managers via comprehensive assessments and follow-ups. Our care managers will play an active role in communicating with enrollees to describe a Smoking Cessation plan, obtain enrollee approval for submittal, will handle the referral process, will communicate with behavioral health providers, and PCPs as needed to obtain and provide updates and ensure all parties are working together to reach smoking cessation goals.

Behavioral health providers, PCPs and FCC care managers are expected to maintain an open line of communication to maintain effective identification of targeted enrollees, maintain effective care throughout the program and to ensure updates are communicated and recorded accordingly.

Alcohol or Substance Use Disorder Recovery Program.

As part of our medically approved alcohol or substance use disorder recovery program, FCC offers annual alcohol or substance use disorder screening training to its providers. FCC requires that all PCPs screen enrollees for signs of alcohol or substance use disorder as part of prevention evaluation at specific times throughout the year.

Enrollees will be identified by our care managers via comprehensive assessments and follow-ups. Our care managers will play an active role in communicating with PCPs to advise of possible enrollment in the program, will communicate with enrollees to describe the Substance Use Program, obtain enrollee approval for submittal, will communicate with behavioral health providers, and PCPs as needed to obtain and provide updates and ensure all parties are working together to reach Substance Use Program goals.

Weight Loss Program

FCC's behavioral health weight loss program has been created to prevent obesity, reduce illnesses that can be caused by obesity and to improve the overall health of its enrollees.

Enrollees will be identified by our care managers via assessments to determine possible eligibility for the program. Our care managers will educate the enrollee regarding the weight loss program, will update enrollee care plan with weight loss intervention, complete weight loss assessments, BMI and weight loss goals. The enrollee will receive a weight loss agreement and is expected to sign the agreement should they agree to participate in the plan. The enrollee will be connected with a licensed dietician who will be added to enrollee's care team.

The Care Manager also communicates with participating PCP to advise of possible enrollment in the program, updates, and weight loss goals. The PCP is expected to provide enrollee further information on healthy lifestyle choices and to assist in the documentation and recording of enrollee status/progress as well as to document earned rewards. Once goals are met, the care manager will mail enrollee rewards to the known address of enrollee.

For more information on the programs above, including required provider training materials and the roles of each caregiver, please access our website at www.fcchealthplan.com.

Cultural Competency

Cultural Competency is the ability to interact effectively with people of different cultures. In practice, both individuals and organizations can be culturally competent. Culture can include race, ethnicity, age, gender, sexual orientation, disabilities, religion, income level, education, geographical location, or profession. FCC has developed a Cultural Competency Program (CCP) to ensure the delivery of culturally competent services and provision of linguistic access to all enrollees of Florida Community Care's LTC Plus plan, including those with limited English proficiency. The CCP was organized around the Culturally and Linguistical Appropriate Services (CLAS) Standards as developed by the Department of Health and Human Services, Office of Minority Health (OMH). The CLAS Standards provide a blueprint for health care organizations to implement culturally and linguistically appropriate services that will advance health equity, improve quality and help eliminate health care disparities.

FCC will provide effective language access services, including interpreters and printed materials in multiple languages that reflect the cultural/ethnic/racial composition of our enrollee population. Language assistance options are available at no cost to the enrollee. Oral interpretive services are available either in-office or telephonically. Providers are able to obtain interpreter services for telephonic contact and in- office visits by calling 1-833-FCC-PLAN, Option 2. Information on how to obtain these services is documented in this Provider Handbook and through other means such as the Provider Newsletter and FCC Provider website.

- Language Line services are available 24 hours a day, seven days a week in 140 languages to assist providers and enrollees in communicating with each other during urgent/emergent situations, non-urgent/emergent appointments as requested, or when there are no other translators available for the language requested.
- TDD/TTY access for enrollees who are hearing impaired is available through 711.

Providers, staff supporting providers and Community Based Organizations receive cultural competency training during provider orientation. Florida Community Care Providers and their staff may participate in Cultural Competence Training which is available 24/7 on our website at www.fcchealthplan.com. For more information on the program above, or to access our Cultural Competency Plan, please access our website at www.fcchealthplan.com.

Enrollee Complaints, Grievances, and Appeals

Florida Community Care has established a process for reviewing enrollee complaints and grievances or appeals. The purpose of this process is to facilitate review of, among other things, an enrollee's dissatisfaction with the Plan, its administrative practices, benefit coverage and payment determinations, or with the administrative practices and/or the quality of care of any of the independent contracting health care providers in the Florida Community Care provider network The Grievance and Appeal Process also permits an enrollee, or his/her physician, to expedite the Plan's review of certain types of complaints or grievance or appeals. Enrollees must follow the process set forth below in the event of a complaint, grievance or appeal. All references to "enrollee" also include an enrollee's authorized representative.

Enrollee Complaints and Grievances

Grievance refers to any enrollee complaint other than one involving an adverse benefit determination as described under the appeal section. Examples are waiting times and provider behavior, adequacy of facilities, formulary and/or its administration, the quality of service received and other similar enrollee concerns.

Under the plan's grievance process, an enrollee may bring his/her dissatisfaction to our attention either informally or formally. We encourage enrollees to seek informal resolution of any dissatisfaction by calling our enrollee services line. If we are unable to resolve the matter on an informal basis within one (1) business day of the date the complaint was received, we will consider the complaint a grievance. Enrollees may submit their formal request for review in writing.

While an enrollee is not required to use a Florida Community Care Grievance Form, the Plan strongly urges an enrollee to submit his/her grievance on such a form. Forms may be obtained by calling the enrollee services number listed on the ID card. Upon request, enrollee services representatives will assist the enrollee in preparing the grievance. Hearing and speech impaired enrollees may contact us by dialing 711.

Enrollee Appeal Review Process

An appeal results from an adverse benefit determination regarding medical necessity/appropriateness. A provider acting on behalf of an enrollee may initiate an appeal following a notice of adverse benefit determination by Florida Community Care. In order to begin the formal review process, submit an Appeal Form to Florida Community Care at:

Grievances and Appeals Address

Florida Community Care Attn: Grievances
and Appeals PO Box 261060
Miami, FL 33126

If the provider or enrollee is unable to obtain an Appeal Form, the plan will accept a detailed letter from the enrollee in lieu of said form. An acceptable letter should:

- Explain the facts and circumstances related to the grievance/appeal.

- Include as much backup information as possible such as copies of any relevant documentation.

Though enrollees are not required to use an Appeal Form, we do strongly urge them to do so in order to facilitate the logging, identification, processing, and tracking of their grievance/appeal through the plans established review process. An enrollee may request the necessary forms by calling the enrollee services number located on the back of their Plan ID card.

Providers and enrollees may also file an appeal by calling Florida Community Care at 1-833-FCC-PLAN. Hearing and speech impaired enrollees may contact Florida Community Care by dialing 711.

Expedited Appeals

Enrollee appeals are handled as expeditiously as the situation warrants; however, there are three situations where the enrollee has the right to file an expedited appeal. When an expedited appeal is filed, the plan must respond to the enrollee within 48 hours in the following situations:

- When taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain or regain maximum function, or

- To advise the enrollee that their request for an expedited appeal does not meet criteria and inform them that standard timeframes have been applied to their case.

An expedited appeal can be requested by the enrollee, his or her representative or a provider acting on behalf of the enrollee (a provider does not have to be an appointed representative to request an expedited appeal on behalf of the enrollee) by submitting an oral or written request directly to us.

If the request is from the enrollee, Florida Community Care must provide an expedited appeal if we determine that applying the standard appeal timeframes would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

If Florida Community Care denies a request for an expedited appeal, the appeal becomes a standard appeal subject to the 30 calendar-day time frame. Florida Community Care promptly notifies the enrollee verbally; by telephone or in person by the close of business on the day of the resolution. Florida Community Care sends a written letter within 2 calendar days of the disposition explaining that the request will be processed using the 30-day standard reconsideration time frame. The letter informs the enrollee of the right to file a grievance if the enrollee disagrees with a decision not to expedite. Instructions about the grievance process and timeframes are also included.

Enrollee Standard Appeals

The attending physician, if authorized to do so by the enrollee, may act on behalf of the enrollee to request a standard review of an adverse benefit determination made by the Plan.

If, after review of the clinical information received, the Florida Community Care Medical Director does not approve benefit coverage for payment of the service(s) requested, the enrollee and

enrollee's physician will be notified in writing of the adverse benefit coverage determination and the enrollee's right to appeal the determination.

All treating physicians have the opportunity to discuss any adverse benefit determination based on medical necessity/appropriateness with the Medical Director who made the decision. The written explanation of this procedure is included within each adverse benefit determination notification.

If a request is made by or supported by a provider, we must provide an expedited reconsideration if the provider indicates that applying the standard reconsideration timeframes would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Medicaid Fair Hearings

Enrollees may ask for a fair hearing at any time up to 120 days after they get a Notice of Plan Appeal Resolution by calling or writing to:

Agency for Health Care Administration
Medicaid Fair Hearing Unit
P.O. Box 60127
Ft. Meyers, FL 33906
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

If an enrollee requests a fair hearing in writing, they must include the following information:

- Name
- Member number
- Medicaid ID number
- Phone number where they and/or their representative can be reached

The following information may also be included:

- Why they think the decision should be changed
- Any medical information to support the request
- Who they would like to help with your fair hearing

Enrollee Assistance with Grievance and Appeals

We shall offer to meet with the enrollee if the enrollee believes that such a meeting will help the Plan resolve the grievance or appeal to the enrollee's satisfaction. The meeting will be held the Plan's local office within the service area or at such other mutually agreeable location within the service area that is convenient to the enrollee. The enrollee may elect to meet with Plan representatives in person, by telephone conference call, or by video-conferencing (if facilities are available). Appropriate arrangements will be made to allow telephone conferencing or video conferencing to be held at the administrative offices of Florida Community Care within the service area. The Plan will make arrangements with no additional charge to the enrollee. The enrollee must notify the Plan that he/she wishes to meet with Florida Community Care representatives concerning the grievance or appeal.

The enrollee has the right to submit oral or written documents, records, or other information relating to their grievance or appeal.

We will provide to the enrollee any of the forms necessary with each written decision letter or upon request of the enrollee. The enrollee may obtain such forms by calling the enrollee services number on the ID card.

Quality Improvement Programs

Quality Programs

Physician and Provider contracts require participation in our Quality Improvement Programs. As part of our Quality Improvement Programs, we may utilize information such as claims, encounter data and/or medical record data to improve the health care of our enrollees.

Florida Community Care QI Programs include; but are not limited to, the following:

- Clinical Practice Guideline Monitoring and Improvement
- Condition-Specific Interventions and Programs
- Credentialing/Re-credentialing
- Delegated Quality Management
- Incident Reporting
- Enrollee and Provider Satisfaction Surveys
- Preventive Health Monitoring and Improvement
- Quality Performance Indicators
- Quality Programs Combined
- Under-Utilization and Over-Utilization Assessment

Quality Enhancement Programs

FCC offers and coordinates quality enhancements (QE) for enrollees with both LTC and MMA Coverage. FCC collaborates actively with community agencies and organizations to ensure that the QE programs are accessible to enrollees and ensures documentation in the enrollee record of referrals to the community program as well as follow-up on enrollee's receipt of service from the community program. FCC quality enhancements are administered and monitored by the FCC Quality Improvement staff.

For FCC's enrollees with LTC benefits, FCC offers the following quality enhancements:

- Safety concerns in the home and fall prevention; and
- End of life issues, including information on advanced directives.

For FCC's enrollees with MMA benefits:

- Children's Programs - FCC does not have membership under age 18, however FCC makes a good faith effort to involve enrollees in existing community children's programs for those enrollees aged 18-20.

- Domestic Violence - FCC ensures that PCPs screen enrollees for signs of domestic violence and shall offer referral services, as applicable, to domestic violence prevention community agencies.
- Pregnancy Prevention - FCC makes a good faith effort to involve enrollees in existing community pregnancy prevention programs. The programs shall be targeted towards teen enrollees, but shall be open to all enrollees, regardless of age, gender, pregnancy status, or parental consent.

- Pregnancy Related Programs –

- FCC provides regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with FCC's prenatal and postpartum programs. FCC coordinates its efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services.
- FCC ensures that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate.
- FCC ensures that providers give all women of childbearing age HIV counseling and offers them HIV testing. (Chapter 381, F.S.)

- Healthy Start Services –
  - FCC develops agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination/case management for pregnant women and infants.
  - The program for pregnant women and infants is aimed at promoting early prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes.
  - FCC collaborates with the Healthy Start care coordinator within the enrollee's county of residence to assure delivery of risk-appropriate care.
  - FCC submits a completed Practitioner Disease Report Form (DH Form 2136) to the Perinatal Hepatitis B Prevention Coordinator at the local CHD for all prenatal or postpartum enrollees and their infants who test HBsAg-positive.

- Nutritional Assessment/Counseling –
  - FCC ensures that its providers supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children.
  - FCC determines the need for non-covered services and referral of the enrollee for assessment and refers the enrollee to the appropriate service setting (to include referral to WIC and Healthy Start and other social services) with assistance.
  - FCC:
    - Ensures the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of breast milk substitutes.
    - Offers a mid-level nutrition assessment.
    - Provides individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or physician following the nutrition assessment
    - Refers all enrollees under the age of five (5), and pregnant, breastfeeding and postpartum enrollees to the local WIC program office using the Florida WIC Program Medical Referral Form (DH 3075).
  - For subsequent WIC certifications, FCC ensures that providers coordinate with the local WIC office to provide the above referral data from the most recent well-child visit for members between 18 years of age and under 21 years old.
  - Each time the provider completes a WIC referral form, FCC ensures that the provider gives a copy of the form to the enrollee.

- Behavioral Health - FCC's care managers provide outreach to homeless and other populations of enrollees at risk of justice system involvement, as well as those enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity shall be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system. For more information on behavioral health, contact the enrollee's case manager at 1-833-FCC-PLAN.

As a provider, we count on your open communication, participation, and cooperation in this process to ensure proper care of enrollees that are involved in this program.

Some provider responsibilities and requirements for FCC QE Programs are:

- Providers shall collaborate with plan and enrollee regarding end of life issues, including information on advanced directives
- PCPs shall screen enrollees for signs of domestic violence
- Providers shall supply voluntary family planning, including a discussion of all methods of contraception, as appropriate.
- Providers shall give all women of childbearing age HIV counseling and offer them HIV testing. (Chapter 381, F.S.)
- Providers shall supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children
- For subsequent WIC certifications, providers shall coordinate with the local WIC office to provide referral data from the most recent well-child visit.
- Each time the provider completes a WIC referral form, provider shall give a copy of the form to the enrollee.

Quality Performance Indicators

Performance measures have been selected for the purpose of assessing certain “process of care” and/or “outcome of care” dimensions for each important aspect of care and service.

- Measures serve as indicators to both consumers and the public in evaluating how well the Florida Community Care health care delivery system is meeting customer needs in these areas.

- Measures can also be used by health care providers to evaluate and improve care and service to enrollees.

- The performance measures were developed through review of work conducted by leaders in the field of health care quality improvement.

- Currently the Plan reports both HEDIS and CAHPS data sets.

Audit Programs

All participating providers are required to comply with our audit programs and to cooperate and assist us in conducting audits of claims submitted. Audits are intended to determine if claims payments were accurate. If a provider fails to follow the procedures for disputing or contesting an audit finding, then we may proceed with collection of such amounts as allowed by law, including but not limited to, offsetting against other amounts due to provider.

We may request medical records or supporting documentation in connection with an audit. If we request medical records, you will provide copies of those free of charge unless otherwise required by law or contract.

All audits will be conducted in accordance with any applicable state or federal laws or requirements along with any provisions set forth in a provider's agreement with us.

Notification/Confirmation Responsibilities:

- Prior to a provider audit, Florida Community Care will send the provider written notice of the upcoming audit 10 working days prior to the audit start date. Audit notifications can be sent to the provider by email, mail, or fax.
- The notification will at a minimum indicate the following:
  - Type of audit
  - When applicable, a list of claims to be reviewed; containing claim number, enrollee name, patient account number, and date of service
- A request for medical documents or components to support billing
- The plan may request a formal entrance conference with applicable provider designee and our audit staff when conducting an Onsite Audit. The formal entrance conference will be held on day one of the onsite visit.

Note: *Certain targeted audits are conducted without prior notification to the provider. In these instances, the provider will have the opportunity to respond to the findings.*

Provider Audit Responsibilities:

Florida Community Care requires the provider acknowledge receipt of audit notification in writing. Said acknowledgment should include at a minimum:

- Contact name and telephone number for individual(s) responsible for coordinating the audit and the provider designee responsible for finalizing and approving audit findings
- For onsite audits, confirmation of the date, time and location for the entrance conference and, if applicable, medical record review
- If requested, provide facilities for the entrance and exit conference and ensure attendance by staff authorized to approve audit findings.

During the audit, the provider agrees to:

- Provide all charts, invoices, itemized bills, financial records, and other data requested to support the documentation of claims payment accuracy
- Provide copies of requested documentation, to be given to auditor or mailed to appropriate address as directed by the auditor.

Audit Findings:

- The provider designee will review/communicate the preliminary audit findings with provider personnel authorized to finalize audit findings.
- Provide formal acceptance of each finding in anticipation of the exit process.

- When applicable, refund enrollee copayments and correct the audited accounts to ensure no further adjustment activity occurs.

Florida Community Care Audit Responsibilities:

- Perform audit
- Discuss preliminary findings with the provider. Discussion and revision of the audit findings may be conducted by telephone, fax, mail or additional onsite meetings.
- Mail a copy of the preliminary audit findings to provider designee. Discussion and revision of the audit findings may be conducted by telephone, fax, mail or additional onsite meetings.

Plan Responsibilities in Exit Process:

An exit conference will be conducted with provider designee; including an overview of audit findings. Exit conferences may be conducted via telephone if in person conference is not required.

- Discussion of overpayment recovery process: Upon completion of the audit, if overpayments are discovered, repayment will be requested from the provider, to be mailed to the Florida Community Care Overpayment Recovery lockbox with audit summary attached (refer to Overpayment Recovery) or recoupment may be initiated by offsetting refunds due to us.
- In cases where the provider requests the use of the offset payment methodology, no checks should be sent to us. Using the offset process will significantly reduce the potential for duplicate recovery processing.

A final exit letter documenting agreed upon audit results, terms of collections for overpayment, and names of the designees present at the exit will be supplied following the audit.

Vendor Audits

We may use contracted vendors to supplement audit activities when considered necessary to reduce risk and exposure to the company. Contracted vendors must follow all audit procedures when conducting audits for us. Vendor activities are centrally coordinated by Florida Community Care to ensure statewide consistency. In these audits, the provider will need to send the check to the address contained in the audit letter, not directly to Florida Community Care. The directions indicated in the audit letter need to be followed to ensure appropriate adjustments and credits are made to the audited claim.

Provider Non-Compliance/Penalties

If it is determined through provider audits, or any other means, that a provider is non-compliant with encounter/claim data submission requirements, the following steps will be taken:

- The provider will be notified in writing and we will place the provider on corrective action for 30- days. During this time, we will work with the provider to achieve compliance.

- Provider compliance will be re-assessed after 30-days. If it is determined that a provider is complying with encounter/claim data submission requirements, the provider will be removed from corrective action. However, if the provider is still non-compliant after 30-days, we may initiate termination of the Agreement.