



PROVIDER HANDBOOK

Effective March 2024

Welcome Letter

A Message from Our CEO:

Welcome to the Florida Community Care (FCC) team. Thank you for choosing to partner with our plan. As a Provider Service Network (PSN), we are committed to building productive and mutually beneficial connections with all providers who serve our enrollees.

FCC is a health plan in the Florida Statewide Medicaid Managed Care Program (SMMC) and is authorized to provide comprehensive health care services to Medicaid enrollees. In addition to our work as a long-term care plan serving Florida's elders, FCC was recently selected to implement a pilot program offering comprehensive and integrated care to persons with intellectual and developmental disabilities. We look forward to collaborating with you to deliver quality medical care, social support, and long-term care services.

FCC is on a mission to improve quality of life for the most vulnerable people. To achieve this mission, we need you—with your specialized capabilities and professional experience—on our team of compassionate providers. Together, we will ensure person-centered, comprehensive health and social care for FCC's members.

We will work closely with you to meet our members' needs and good communication will be a key component of our success in this effort. Please know that our staff will respond to your questions, address your concerns, and work with you to solve any problems you identify. We will always do our best to earn your trust and goodwill.

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

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

Thank you again.

A handwritten signature in blue ink, reading "Nestor Plana".

Nestor J. Plana

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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 several components: the Long-term Care (LTC) program, the Managed Medical Assistance (MMA) Standard or Specialty programs, and the Dental Program. Members who qualify for both the LTC and MMA programs will receive their benefits from the same health plan. Florida Community Care is

the only Long-term Care Plus Plan in Florida's Medicaid program. We cover Enrollees statewide and offer LTC and MMA benefits to our Enrollees based on their eligibility.

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

[http://www.ahca.myflorida.com/Medicaid/statewide mc/](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. Many of our members are also eligible for MMA services. The health plan will collaborate 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 special needs, such as Dementia/Alzheimer's

FCC Enrollment

The FCC enrollment is composed of two Enrollee types: Dual Eligible and Non-Dual Eligible Enrollees.

1. **Dual Eligible Enrollees** are those enrollees that have dual coverage of both Medicare and Medicaid. Dual eligibility Enrollees (Duals) are entitled to receive Medicare Part A and/or Part B and Part D benefit coverage. Thereby, Medicare acts as the Enrollee's primary payer by means of Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services. Part D covers all pharmacy benefits that include all oral and self-injectable drugs. Enrollees are covered by Medicare by two methods: Medicare Primary Fee-For-Service and Medicare Part C through an HMO product. Duals have the added benefit of Long-term Care (LTC) when they meet nursing-home level of care as determined by the State. Florida's SMMC LTC benefits are not supplements, a wrap-around or secondary carrier to Medicare. LTC is a separate and distinct benefit that provides an array of both nursing home and home and community-based services that enable enrollees to live in the community and to avoid institutionalization.
2. **Non-dual Eligible Enrollees** are those enrollees that do not have Medicare as their primary benefit plan. These Enrollees have FCC as their LTC benefit plan PLUS they have eligibility for Florida Medicaid's MMA (medical benefit). In this case, FCC provides both MMA and LTC benefits for these Enrollees.

Non-Payment for Medicare Covered Services

FCC does not cover products and services (both CPT and HCPCS codes) that are covered under Medicare Parts A, B, and D or under a Part C plan for dual-eligible. Medicare is the primary source of coverage and payment for these services and FCC is the secondary payer.

Florida Medicaid precludes SMMC plans to provide duplicative coverage for those covered services that are covered under both under Medicare and Florida. A Medicare-covered service denied by Medicare and covered under LTC benefit is not automatically covered by Medicaid. All requests denied by Medicare must be reviewed for medical necessity by FCC.

Role of the FCC Care Manager/ Care Coordinator

FCC Care Managers are responsible for coordinating the continuum of care activities for the enrollees, ensuring optimum utilization of resources to improve their quality of life as well as to assist them to live and work in the setting of their choice.

Our Care Managers performs a variety of activities that include, but not limited to:

- Assessing
- Identifying
- Evaluating
- Coordinating; and
- Managing enrollees and caregivers needs and expectations


Care coordination is one of the primary functions of the Care Manager. It ensures the enrollee needs are being met and prevents fragmentation of care. It involves developing a comprehensive and individualized care plan using a person-centered approach, in conjunction with the enrollee and the caregiver based on identified problems, challenges, barriers, and goals.

Enrollee Identification Cards

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

 <p>FLORIDA COMMUNITY CARE</p> <p>1-833-FCC-PLAN</p> <p>Enrollee Name: [John Doe] Enrollee ID #: [123456-18] Effective Date: 11-01-2018 Medicaid ID #: [123456]</p> <p><small>This card does not prove membership nor guarantee coverage. Call Florida Community Care, LLC. Enrollee Services to confirm benefits/eligibility, and for service authorizations.</small></p>	<p>IMPORTANT CONTACT INFORMATION FOR ENROLLEES</p> <p>Florida Community Care, LLC. www.fcchealthplan.com PO Box 261060 Miami, FL 33126</p> <p>For Enrollee Services or Eligibility Verification: 1-833-322-7526 (TDD/TTY 711), Option 1</p> <p>For Care Management: 1-833-322-7526, Option 2 For Transportation: 1-833-322-7526, Option 3 For Claims or Other Provider Questions: 1-833-322-7526, Option 5 Behavioral Health Benefits: 1-833-322-7526, Option 9</p> <p>Submit Claims to: Florida Community Care, LLC. Attn: Claim Dept. P.O. Box 211322 Eagan, MN 55121</p> <p>Payee ID # [12345]</p>
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For Enrollees with without Medicare coverage, the ID card looks like the images above:

 <p>FLORIDA COMMUNITY CARE</p> <p>1-833-FCC-PLAN</p> <p>Enrollee Name: [John Doe] Enrollee ID #: [123456-18] Effective Date: 11-01-2018 Medicaid ID #: [123456]</p> <p>PRIMARY DOCTOR PCP: [Dr. John Smith] [ABC Practice] [123 Main St.] [Anytown, Anycity AB12345] Ph: [(123)-456-7890]</p> <p>RXBIN: 004336 RXPCN: MCAIDADV RXGRP: RX6444</p> <p><small>This card does not prove membership nor guarantee coverage. Call Florida Community Care, LLC. Enrollee Services to confirm benefits/eligibility, and for service authorizations.</small></p>	<p>IMPORTANT CONTACT INFORMATION FOR ENROLLEES</p> <p>Florida Community Care, LLC. www.fcchealthplan.com PO Box 261060 Miami, FL 33126</p> <p>For Enrollee Services or Eligibility Verification: 1-833-322-7526 (TDD/TTY 711), Option 1</p> <p>For Care Management: 1-833-322-7526, Option 2 For Transportation: 1-833-322-7526, Option 3 For Claims or Other Provider Questions: 1-833-322-7526, Option 5 Pharmacy Benefits: 1-877-888-8347 Behavioral Health Benefits: 1-833-322-7526, Option 9</p> <p>Submit Claims to: Florida Community Care, LLC. Attn: Claim Dept. P.O. Box 211322 Eagan, MN 55121</p> <p>Payee ID # [12345]</p>
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For Enrollees with Medicare coverage (Dual Eligibles), the ID card will look like the images above:

NOTE: You will notice there is no Primary Care Provider (PCP) listed. The Enrollee can **continue to see the PCP and any other doctors they are currently seeing under their Medicare benefits.**

The presentation of 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 or requesting same online at www.fcchealthplan.com.

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 Handbook

This Provider Handbook shall serve as a source of information regarding Florida Community Care covered services, procedures, regulations, contact information, 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.

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*

Practice Name

Department

Contact Name*

Contact Phone

Title*

Address Line 1

Address Line 2

City

State

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. When entering your TIN and NPI, enter numbers ONLY (no dashes or spaces)

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.





MESSAGES INBOX

PROFILE

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ELIGIBILITY

CLAIMS

AUTHORIZATIONS

Select Provider:

Patient Roster

Search Options:
Medicaid ID or Florida Community Care ID only;
Last Name & DOB

First Name:

Florida Community Care ID

Date of Birth:


Last Name:


Search


Patient Roster


No patients found.


Quick Links


 Update My Information


 Frequently Asked Questions


 Provider Handbook (PDF)


 Notices

 Training Documents

 Prior Authorization Request Form (DOC)

 Assisted Living Facility Monthly Event Log (PDF)

 Electronic Funds Transfer/Direct Deposit Form

 Provider Information Update Request Form

External Links

Ability Website

Availity Website

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1-833-FCC-PLAN – www.fcchealthplan.com

Eligibility Results





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PROFILE



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ELIGIBILITY

CLAIMS

AUTHORIZATIONS

Current Member:

View Patient

Subscriber

Member:	<div></div>	Group Name:	<div></div>
Member ID:	<div></div>	Group Number:	<div></div>
DOB:	08/31/1960	PCP:	DEFAULT, PROVIDER
Effective Date:	12/01/2018	Termination Date:	
Status:	Active		

Quick Links

 Update My Information

 Frequently Asked Questions

 Provider Handbook (PDF)

 Notices

 Training Documents

 Prior Authorization Request Form (DOC)

 Assisted Living Facility Monthly Event Log (PDF)

 Electronic Funds Transfer/Direct Deposit Form

 Provider Information Update Request Form

External Links

Ability Website

Availity Website

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).

The screenshot shows the 'CLAIMS' section of the Florida Community Care portal. At the top, there's a navigation bar with 'HOME', 'ELIGIBILITY', 'CLAIMS' (selected), and 'AUTHORIZATIONS'. To the right of the navigation bar are links for 'MESSAGES INBOX', 'PROFILE', and 'LOGOUT'. Below the navigation bar, there's a 'Select Provider:' dropdown menu. Underneath, 'Search Options' are listed: 'Claim Number, Florida Community Care ID, Medicaid ID' and 'Any of the above and Date'. A note states: '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.' A 'Status Legend' is provided: P=Processed, S, C=In Process, R=Reversed, D=Claim Deleted, A=Adjustment in Process, V=Voided. The search form includes a 'Claim Number(s):' field, a 'Florida Community Care ID' dropdown, 'Begin Date:' (4/29/2016), 'End Date:' (4/29/2019), and a 'Check Number' field. A 'Date of Birth:' field is also present. Below the search form are 'Search' and 'View All Claims' buttons. The result shows 'No claims found.' Below this is a 'Quick Links' section with links to 'Update My Information', 'Frequently Asked Questions', 'Provider Handbook (PDF)', 'Notices', 'Training Documents', 'Prior Authorization Request Form (DOCX)', 'Assisted Living Facility Monthly Event Log (PDF)', 'Electronic Funds Transfer/Direct Deposit Form', and 'Provider Information Update Request Form'. At the bottom is an 'External Links' section.

FLORIDA COMMUNITY CARE

MESSAGES INBOX PROFILE LOGOUT

HOME ELIGIBILITY **CLAIMS** AUTHORIZATIONS

Select Provider:
[Dropdown]

Search Options:
Claim Number, Florida Community Care ID, Medicaid ID
Any of the above 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.

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

Claim Number(s): [Text Field]
Florida Community Care ID [Dropdown]
Begin Date: 4/29/2016 [Text Field]
End Date: 4/29/2019 [Text Field]
Check Number [Text Field]
Date of Birth: [Text Field]

Search View All Claims

No claims found.


Quick Links




- Update My Information
- Frequently Asked Questions
- Provider Handbook (PDF)
- Notices
- Training Documents
- Prior Authorization Request Form (DOCX)
- Assisted Living Facility Monthly Event Log (PDF)
- Electronic Funds Transfer/Direct Deposit Form
- Provider Information Update Request Form

External Links

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.





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CLAIMS

AUTHORIZATIONS

Select Provider:

[Click here to ask a question about this claim](#)

Show/Hide Search

Claim Number(s):

Florida Community Care ID ▾

Date of Birth:

Begin Date:
4/29/2016

End Date:
4/29/2019

Check Number

Search

[View All Claims](#)

Claim #

Date Received: 02/27/2019

Member:

Member ID:

Provider Name:

Provider ID:

Account Number:

Date Paid: 03/05/2019

Check Number:

Status: Processed

Authorization Number:

Primary Diagnosis: R59

Reversal Code:

Reversal Description:

Payment Details

Claim Received	Pay To	Amount	Date Paid
02/27/2019	<div></div>	\$0.00	03/05/2019

Claim Details

DATE(S) OF SERVICE	PROCEDURE CODE(S)	1ST MODIFIER	POS	NOS	CHARGED	ALLOWED	COPAYMENT	TOTAL AMOUNT PAID	EOB CODE	MESSAGE CODE
01/31/2019	T2030		13	1	\$35.48	\$0.00	\$0.00	\$0.00		41
Total Interest								\$0.00		
Total Discount								\$0.00		
Total					\$35.48	\$0.00	\$0.00	\$0.00		

Check Summary

DATE PAID	CHECK NUMBER	PAYEE ID	PAYEE NAME	BULK AMOUNT
03/05/2019	<div></div>			\$0.00

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:	<input type="text"/>
* Provider ID Number:	<input type="text"/>
* Provider Name:	<input type="text"/>
* CIN/Member ID Number:	<input type="text"/>
* Patient Name:	<input type="text"/>
* Date of Service (MM/DD/YYYY) :	<input type="text" value="1/31/2019"/>
Procedure Code(s) In Question:	<input type="text"/>
* Billed Amount:	<input type="text" value="\$35.48"/>
* Request For:	<input type="text" value="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

Authorization Inquiry

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 the type of authorization, as well as start and end dates.

The screenshot shows the Florida Community Care website interface. At the top left is the Florida Community Care logo. At the top right are links for Messages In Box, Profile, and Logout. Below these is a navigation bar with links for Home, Eligibility, Claims, and Authorizations (which is highlighted). The main content area is titled 'Authorizations Search'. It includes a link to 'Click Here to Submit a Prior Authorization Request'. Below this is a section for 'Search Authorizations By:' with filters for 'Authorization types' (All authorization types, Outpatient, Inpatient) and 'Authorization status' (Any authorization status, Pending, Approved, Denied). There are also filters for 'All', 'Authorization ID', and 'Florida Community Care ID'. A date range selector is present with 'Authorization date' (Date of Service), 'From*' (01/29/2019), and 'To*' (04/29/2019). A 'Search' button is located below the date range. At the bottom of the search section is a 'Quick Links' list with various links: Update My Information, Frequently Asked Questions, Provider Handbook (PDF), Notices, Training Documents, Prior Authorization Request Form (PDF), Assisted Living Facility Monthly Event Log (PDF), Electronic Funds Transfer/Direct Deposit Form, and Provider Information Update Request Form.

FLORIDA
COMMUNITY CARE

MESSAGES IN BOX PROFILE LOGOUT

HOME ELIGIBILITY CLAIMS **AUTHORIZATIONS**

Authorizations Search

[Click Here to Submit a Prior Authorization Request](#)

Search Authorizations By:

Authorization types

* All authorization types * Outpatient * Inpatient

Authorization status

* Any authorization status * Pending * Approved * Denied

* All * Authorization ID * Florida Community Care ID

Authorization date From* To*

Date of Service 01/29/2019 04/29/2019

Search

Quick Links

- Update My Information
- Frequently Asked Questions
- Provider Handbook (PDF)
- Notices
- Training Documents
- Prior Authorization Request Form (PDF)
- Assisted Living Facility Monthly Event Log (PDF)
- Electronic Funds Transfer/Direct Deposit Form
- Provider Information Update Request Form

Authorization Results



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View Authorization

Home / Authorizations Search / View Authorization

Print

Authorization # [REDACTED]

Authorization #	[REDACTED]	Status:	APPROVED	Approved Type:	PXA
Requested Dates of Service:	[REDACTED]	Requesting Provider:	[REDACTED]	Servicing Provider:	[REDACTED]
Member Name:	[REDACTED]	Member ID:	[REDACTED]	Date of Birth:	[REDACTED]
Diagnosis Code:	[REDACTED]	Description:	[REDACTED]		

Service Details

Status:	APPROVED						
Approved Dates of Service:	4/1/2019						
Place of Service:	ASSISTED LIVING FACILITY						
Procedure Code	Description	Status	Mod 1	Mod 2	Mod 3	Mod 4	Approved Units
T2030	ASSISTED LIVING WAIVER, PER MO	APPROVED					6

Providers

Servicing Provider	
Provider:	[REDACTED]
Phone Number:	[REDACTED]
Servicing Provider NPI:	[REDACTED]
Address:	[REDACTED]
Requesting Provider	
Provider:	[REDACTED]
Phone:	[REDACTED]
Requesting Provider NPI:	[REDACTED]
Address:	[REDACTED]

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
- Educational Bulletins
- Notices on our Provider Portal

For New Provider Orientation, please visit the website and select New Provider Orientation to select the date & time that is most convenient for you. Training materials are available through the health plan website at www.fcchealthplan.com; or by calling 866-962-6186 and request assistance with Provider Education.

Florida Community Care's Provider Network

LTC and MMA 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, we may not be accepting additional providers to participate in our provider network. To initiate a request to join our network, please contact FCC Provider Relations at 866-962-6186 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 the 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 the 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 re-credentialing process much easier.

Long-term Care service providers, facilities, ancillary providers, suppliers, 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, FCC credentialing staff will contact the provider. 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 clean/complete application.

Completion and submission of the application and the required documentation do 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.

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

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.

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 an 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 CFR 160.103 are not required to submit an 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 the gap of 6 + months)
- Copy of specialty board certification, 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.

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 the state license, Joint Commission 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.

Long-Term Care Services 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).

Credentialing Requirements for Advanced Non-Physician Practitioners

Florida Community Care currently defines Advanced Non-Physician Practitioners (ANPP) as Advanced Practice Registered Nurse (APRNs), 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.

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 network.*

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 the applicant 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 of 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
- Always honor an 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, national origin, marital, physical, mental, or socioeconomic status regardless of sex
- 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 Enrollee grievance and appeal 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 an active and valid business email address at all times with Florida Community Care; and any changes to your email address must be reported to Florida Community Care within three (3) business days
- Maintain internet access at all times in order to gain direct access to Florida Community Care's Provider Portal
- Maintain communication with appropriate agencies, such as local police, poison control, and social service agencies to ensure Enrollees receive quality care
- Contact an enrollees' Florida Community Care Manager if an Enrollee exhibits a significant change, is admitted to a hospital, or hospice
- 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 upon in writing

- Meet all timely access standards pursuant to the 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 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 Care Manager/ Care Coordinator
- Immediately notify FCC of an Enrollee's pregnancy, 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 services, 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
- 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.

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

- 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
- Business e-mail address
- 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 Account Executive immediately.

Provider Prohibited and Permitted Marketing Activities

Florida Community Care makes available 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 specifically directed at Florida Community Care Enrollees must be developed at the fourth grade reading level and must have prior written consent from Florida Community Care and the appropriate government agencies. Generic practice materials are permissible. Please contact your Provider Relations Representative for information and review of the 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 Florida Community Care.
- Offer anything of value to induce recipients/Enrollees to select them as their provider.
- Offer inducements to persuade recipients to enroll in any 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 or patient room, waiting rooms, pharmacy counter or other similar patient settings.
- Furnish to any Managed Care Plan lists of their Medicaid patients or the membership of any other Managed Care Plan.

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 the 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 an 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.

Enrollee Rights and Responsibilities

A Florida Medicaid recipient has the following rights:

- Be treated with courtesy and respect
- Have their dignity and privacy respected at all times
- Receive a quick and useful response to their questions and requests
- Know who is providing medical services and who is responsible for their care
- Know what enrollee services are available, including whether an interpreter is available if they do not speak English
- Know what rules and laws apply to their conduct
- Be given information about their diagnosis, the treatment they need, choices of treatments, risks, and how these treatments will help them
- Say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for their 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
- Get a copy of a bill and have the charges explained
- Get the 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 they 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 their rights are not respected
- Ask for another doctor when they do not agree with their doctor (second medical opinion)
- Get a copy of their medical record and ask to have information added or corrected in their record if needed

- Have their medical records kept private and shared only when required by law or with their approval
- Decide how they want medical decisions made if they cannot make them (advanced directive)
- To file a grievance about any matter other than a Plan's decision about their services
- To appeal a Plan's decision about their services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for them 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 they live
- Receive information about being involved in their community, setting personal goals and how they can participate in that process
- Be told where, when, and how to get the services, they need
- To be able to take part in decisions about their health care
- To talk openly about the treatment options for their conditions, regardless of cost or benefit
- To choose the programs they participate in and the providers that give them care

A Florida Medicaid recipient has the following responsibilities:

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

Fraud, Waste, and Abuse

Florida Community Care maintains a comprehensive Fraud, Waste, and Abuse program. The program offers a 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 and unlawful activities that are 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 costs 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 the 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 has 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 Act. 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 of Fraud, Waste, and Abuse

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 others. 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. There are two (2) types of waste: **Quality Waste** includes overuse, underuse, and ineffective use and **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 training on fraud, waste, and abuse. Please contact your Provider Relations Representative for additional information.

Enrollee Abuse, Neglect and Exploitation

Long-Term Care: Enrollee Abuse, Neglect, and Exploitation

Similar to child abuse, neglect and exploitation occurs when an elderly person 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 person's physical, behavioral, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

The Warning Signs

Signs of elder abuse can be difficult to recognize or mistaken for symptoms of dementia or the elderly person's frailty—or caregivers may explain them to you that way. In fact, many of the signs and symptoms of elder abuse do overlap with symptoms of mental deterioration, but that doesn't mean you should dismiss them on the caregiver's say-so.

Frequent arguments or tension between the caregiver and the elderly person or changes in the personality or behavior in the elder can be broad signals of elder abuse. If you suspect abuse but aren't sure, you can look for clusters of the following warning signs. 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

2415 North Monroe Street
Suite 400
Tallahassee, FL 32303-4190
Phone: (850)-488-1429

Enrollee Abuse

This 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.

Enrollee Exploitation

This is where the enrollee is deemed a vulnerable adult when:

- A person 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.
- A person 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 deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property temporarily or permanently for the benefit of someone other than the vulnerable adult.

Enrollee Neglect

This represents an adult that fails or omits 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.

Self Neglect

One of the most common forms of elder abuse met by FCC Care Managers is self-neglect. Physical or mental impairment or diminished ability can mean that an older adult is no longer able to perform essential self-care. They may lack basic personal hygiene, appear dehydrated, malnourished, or underweight, live in increasingly unsanitary or dirty conditions, and be unable to pay bills or properly manage their medications.

Self-neglect can be a sign of depression, grief, dementia, or other medical problem, and in many cases, the older person will refuse to seek help. They may be in denial, feel ashamed about needing help, or worried about losing their independence.

Risk Factors

The following are a list of risk factors that all providers should be familiar with when dealing with an elderly population:

- Depression in the caregiver
- Lack of support from other potential caregivers
- The caregiver’s perception that taking care of the elder is burdensome and without emotional reward
- Substance abuse by the caregiver
- The intensity of the elderly person’s illness or dementia
- Social isolation—the elder and caregiver are alone together almost all the time
- The elder’s role, at an earlier time, as an abusive parent or spouse
- A history of domestic violence in the home
- The elder’s own tendency toward verbal or physical aggression

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

Any actions that result in abuse, neglect or exploitation of an Enrollee by a Home and Community-Based Service provider must be reported to the Agency with a Critical Incident report by FCC.

Critical 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 LTC Plan 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:

- Enrollee death that is otherwise unexpected
- Enrollee death by homicide
- Enrollee death by suicide
- Enrollee death by abuse, neglect, or exploitation
- Enrollee brain damage
- Enrollee spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
- Any condition requiring surgical intervention to correct or control
- Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
- Any condition that extends the patient's length of stay
- Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility
- Suspected abuse, neglect, or exploitation
- Injury or major illness as a result of care provider
- Sexual battery
- Medication errors
- Suicide attempts
- Altercations requiring medical intervention
- Elopement

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.

According to the Adverse Incident Reporting Guide distributed by AHCA, the term "Adverse Incident" means an injury of an enrollee occurring during delivery of Managed Care Plan covered services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and,
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the staff of the Provider." Injuries or incidents that are the result of an adverse incident could include the following:
 - Enrollee Death
 - Enrollee Brain Damage
 - Enrollee Spinal Damage
 - Permanent Disfigurement
 - Fracture or Dislocation of bones or joints
 - Any condition requiring definitive or specialized medical or dental attention which is not consistent with the routine management of the patient's case or patient's preexisting physical or mental condition
 - Any condition requiring surgical intervention to correct or control
 - Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
 - Any condition that extends the patient's length of stay
 - Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility

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, the 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 specialty areas within the geographic access standards:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrician

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 a 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 For Any Reason

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 but must do so in writing to the Plan.

FCC Is Not Involved in the Corporate Practice of Medicine

Florida Community Care is a Provider Service Network; we do not in any way practice medicine, manage care or direct the care and treatment of any FCC Enrollee. FCC's function is to facilitate the coordination of an Enrollee's care and treatment by a network provider who is managing that Enrollee's care and treatment.

An Enrollee's Selection of Providers

FCC shall assist the Enrollee in selecting providers by supplying the Enrollee with a list of applicable providers for him or her to choose from. Selection of a provider is within the purview and responsibility of the Enrollee or his or her treating provider using FCC participating provider directory.

Providers that are making a referral or transferring care to another provider, the referring or transitioning provider is responsible for assisting or selecting the appropriate provider for the Enrollee. Once identified, the Provider then must transmit or transfer the medical records to the receiving or accepting provider. Providers refusing to assist in making referrals or transitioning care to another provider run the risk of being cited for Enrollee abandonment.

Enrollee [Patient] Abandonment

This is an issue that FCC takes seriously because it directly impacts the Enrollee. The care, welfare, and safety of the FCC Enrollee is of paramount concern. FCC has zero tolerance in this regard.

Patient Abandonment refers to withdrawal from the treatment of a patient without giving reasonable notice or providing a competent replacement. There are no state or federal laws that forbid a physician or any provider from firing a patient, for whatever reason. However, the provider cannot abandon a patient on the spot.

The provider must first give the Enrollee notice via written correspondence using certified USPS mail or other trackable private carriers. The served notice must state that the provider-patient relationship has been terminated, either with or without cause.

A provider can sever a provider-patient relationship due to no longer participating in the Florida Medicaid or limiting Medicaid patients. The letter to the Enrollee must allow for 60 days from receipt of the notification to seek another provider of his or her choosing from the list of participating providers within the FCC network. A provider can also select a new

provider for the Enrollee as long as new provider formally accepts the new patient in either verbal or written form.

Once the new provider is selected, the provider must prepare and send all of the Enrollee's medical records in his or her possession to the new provider either electronically or in printed format without charge to the Enrollee.

Note: *When an Enrollee is receiving ongoing treatment from you that no other provider can provide or will provide, and the Enrollee may receive sufficient harm from the stopping of treatment, then the Enrollee has the right to refuse transfer to another provider until the treatment is completed.*

Providers that took care of an Enrollee in an emergency setting and the provider allowed for follow-up care must continue to see that Enrollee. Should the provider not want to continue to see the Enrollee, for any reason whatsoever, the provider can transition the Enrollee out of his or her care as stated by finding a provider of the same specialty that is willing to accept the Enrollee and to whom all clinical records are forwarded. Anything less shall constitute abandonment of the Enrollee.

It should be noted that a provider cannot refuse to see an Enrollee without applying the above criteria. A provider may not just abandon an Enrollee due to any of the following reasons:

- The enrollee refuses to cooperate with the provider and its staff.
- The provider is not a participating provider with Florida Community Care.
- The enrollee will not pay his or her bills.
- Reimbursement for services has been denied by FCC or the provider has ceased to be a Florida Community Care or Medicaid provider.
- You can terminate the provider-patient relationship in the following ways:
 - The physician and the patient mutually agree to terminate the relationship
 - The patient unilaterally dismisses the provider from the enrollee's care and treatment.
- The enrollee is unruly and obnoxious to the point where it is in the best interests of all concerned for the provider to quit providing services.
- The provider terminates the relationship after giving the patient written notice and a reasonable amount of time to find another provider.

Florida Community Care Medical Management

As a Provider Service Network, 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 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 necessary services.

Note: *As an FCC participating provider you are responsible for your active participation in FCC's Medical Management Programs. FCC is constantly upgrading and changing its programs in pursuit of the best quality and outcomes for FCC Enrollees. Some changes are simple and non-material in nature, Others will be material changes. For any changes that are material, FCC will provide 60-days written prior notice of the changes to a UM program. Written notification with the effective date(s) will be sent via your business email. Therefore, it is important to keep your business email up to date with FCC. If you do not have a business email address on file with FCC, now is the time to submit it. FCC will also post all changes to the FCC website.*

Long-term Care Benefits and Services

LTC review for medical necessity represents two types of authorization. The first is service authorization (SA) and the other is the traditional prior authorization (PA). The two are very different from one another. More details into these functions are detailed later in this handbook.

A covered service is any product or service that has been approved by AHCA as covered under the SMMC list of benefits. The list of these benefits can be found on the AHCA website: 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:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/Covered_Services_HCBS_Waivers.shtml

The following table represents all the services that require a service authorization to be entered by the FCC Care Manager in order for an Enrollee to receive the service. These services represent Home and Community-Based Services (HCBS) that are requested either by Enrollee or the caregiver, require medical necessity submission by the treating provider or multiple services that require FCC medical director approval and coordination based on medical necessity.

Service	Description	Prior Authorization
Adult Companion Care	This service is provided in accordance with Florida Medicaid Coverage Guideline 59G.4.192.	Authorization is provided based on specific set of needs of the Enrollee. 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. This service is provided in accordance with Florida Medicaid Coverage Guideline 59G.4.192.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Assistive Care Services	These are 24-hour services available in an adult family care home or an assisted living facility.	Authorization is provided based on specific set of needs of the Enrollee. 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 specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Attendant Nursing Care	Nursing services and medical assistance provided in the home to help you manage or recover from a medical condition, illness, or injury.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.

Service	Description	Prior Authorization
Behavioral Management	Services for mental health or substance abuse needs.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Caregiver Training	Training and counseling for the enrollees' caregivers.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Care Coordination/ Case Management	Services that help with the services and support enrollees need to live safely and independently. This includes having a Care Manager and making a plan of care that lists all the services needed.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.

Service	Description	Prior Authorization
Home Accessibility/ Adaptation Services	The provision of physical adaptations and renovations to the Enrollee's house to ensure the health, safety, and welfare of the enrollee, or to enable the enrollee to function with greater independence in the home, without which an enrollee would require institutionalization. Adaptations such as, grab bars, ADA toilets and sinks; and removable ramps do not require the Enrollee to own the house. For any renovations to the physical structure or attachment to the physical structure of the house, the Enrollee must hold ownership in total or part of house as documented in the county property records of the physical address. Covered in accordance with Florida Medicaid 59G.4.192 Coverage Guideline.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Home Delivered Meals	This service delivers healthy meals to the home. Covered in accordance with Florida Medicaid 59G.4.192 Coverage Guideline.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Homemaker Services	This service helps with general household activities, like meal preparation and routine home chores. Covered in accordance with Florida Medicaid 59G.4.192 Coverage Guideline.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.

Service	Description	Prior Authorization
Hospice	For Dual Enrollees, this benefit is covered under Part A of Medicare. For Non-Dual Enrollees, Florida Medicaid MMA provides the coverage. 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.	Enrollee must be certified as a hospice candidate by the hospice medical director or by his/her PCP or designated specialist that the Enrollee's status is terminal, with no possibility of reversal of the primary disease; and the Enrollee has less than six (6) months of life remaining. Please refer to CMS Medicare Chapter 9 or Florida Medicaid for complete details. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Intermittent and Skilled Nursing	Nursing care and service when a skilled need to present. For Dual Enrollees, this benefit is covered under Medicare. For Non-Dual Enrollees, Florida Medicaid MMA provides the coverage.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Durable Medical Equipment and Consumable	Medical equipment is used to help manage and treat a condition, illness, or inj	Appliances, equipment, supplies, or other items normally or usually recognized by

Service	Description	Prior Authorization
Supplies	<p>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. Coverage for Dual is by Medicare FFS or Part C plan. Non-Dual is under the MMA benefit.</p> <p>Consumable supplies that are consumable, expendable, disposable, or non-durable to sustain the recipient at home or in the community. All eligible products are covered under the LTC benefit for all Enrollees.</p>	<p>medical professionals as medically necessary in the treatment of or rehabilitation from the covered illness or injury, including drugs and durable medical equipment. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.</p>
Medication Administration	Help with managing and assistance to enrollee with taking medications.	Authorization is provided based on specific set of needs of the Enrollee. 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 enrollee is taking.	Authorization is provided based on specific set of needs of the Enrollee. 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 specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour	Authorization is provided based on specific set of needs of the Enrollee.

Service	Description	Prior Authorization
	nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology.	Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Personal Care	These are in-home services to help with: <ul style="list-style-type: none"> • Bathing • Dressing • Eating • Personal Hygiene 	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Personal Emergency Response (PERS)	An electronic device to wear or keep near you that allows a call for emergency help anytime.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Respite Care	This service lets caregivers take a short break. This service is available in the home, an Assisted Living Facility or a Nursing Home.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Occupational Therapy	Occupational therapy includes treatments that help with daily life, like writing, feeding, and using items around the house.	Authorization is provided based on specific set of needs of the Enrollee. 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 the body get stronger and feel better after an injury, illness, or because of a medical condition.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Respiratory Therapy	Respiratory therapy includes treatments that help an enrollee breathe better.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.
Speech Therapy	Speech therapy includes tests and treatments that help an enrollee talk or swallow.	Authorization is provided based on specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.

Service	Description	Prior Authorization
Transportation / Non-Emergency Medical	Non-emergency transportation to and from all 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 specific set of needs of the Enrollee. Contact the Enrollee's Care Manager for assistance at 1-833-FCC-PLAN.

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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.

Managed Medical Assistance Benefits and Services (MMA)

As of the date of publication of this Handbook, the following is a list of core benefits and services (Covered Services) that are provided to Florida Medicaid Enrollees under the MMA (Non-Dual) Benefit only. Please note that this section does not apply to Enrollees who have Dual Medicare/Medicaid coverage where Medicare FFS or a Medicare Part C HMO is the primary payer for those enrollees and whereupon, FCC is the secondary or wrap around payer.

The Florida Community Care prior authorization process applies to all enrollees and is associated with those specific CPT and HCPCS codes as defined by the Agency for Health Care Administration (AHCA) and represented as Agency Assigned Prior Authorization Codes (AAPAC). The requirement for each AAPAC is set up exclusively by AHCA, along with its designated fee.

FCC has also designated certain CPT and HCPCS, along with the designated AAPAC as represented as Essential Prior Authorization Code (EPAC) as prescribed by Florida Community Care. These codes have designated prior authorization status under the following three topic headings:

1. Medical/Surgical /Ancillary
2. Pharmaceuticals/Biologicals/Infusion Therapy/Enteral
3. Behavioral Health

The rationale for that designation is represented as:

- Procedures, treatments, drugs, or equipment that are inappropriate, have dangerous side effects or are experimental or investigational in nature.
- Procedures, treatments, drugs, or equipment that are the extreme forms of treatment in both cost and risk that require a reasonable level of discourse as to the rationale for that particular choice by the requesting or prescribing provider.
- Procedures, treatments, drugs, or equipment that are off-label and should be used only for certain health conditions.
- Procedures, treatments, drugs, or equipment that are often misused or abused.
- Procedures, treatments, drugs, or equipment that a provider requests or prescribes when less expensive procedures, treatments or drugs will work just the same.

The following is a list of topics that are associated with either AAPAC or EPAC prior authorization requirements:

Medical/Surgical/Ancillary

- Durable Medical Equipment
- Prosthetics and Orthotics
- Non-emergent/Elective Acute Inpatient Medical and Surgical Hospitalization
- Post-acute Skilled Nursing Facility and Skilled Rehabilitation
- Acute Inpatient Rehabilitation
- Home Health Care Services not associated with HCBS
- Physical, Occupational, Speech, Pulmonary, and Cardiac Therapies
- Home Infusion Therapy
- Place of Service review
- Allied health provider services, chiropractic, and podiatric care
- Interstate medical transportation via land or air
- All customized products
- Private duty nursing other than provider under the HCBS
- Power operated vehicle (POV) (motorized wheelchairs or scooters)
- Experimental or investigational services
- A product or service under an unlisted CPT or HCPCS codes, including all new healthcare technologies that are not represented by a designated CPT or HCPCS code
- A product or service that does not meet the criteria/guideline for medical necessity, but is otherwise reasonable or appropriate because of specific mitigating circumstances
- Cosmetic procedures requested as reconstructive or restorative to function (e.g., rhinoplasty, septoplasty, blepharoplasty)
- Any out-of-network facility, non-participating professional provider, and vendors
- Advanced radiological diagnostics (e.g., computerized tomography (CT) scans, magnetic response imaging (MRI), positron emission tomography (PET) scans, nuclear medicine.
- All transplant surgical request

Pharmaceuticals/Biologicals/Infusion – Therapy/Enteral

- Drugs requested on an “off-labeled” basis
- Drugs not listed on the Agency Preferred Drug List (PDL)
- Drugs listed on the PDL with a prior authorization
- All specialty drugs that do not appear on the PDL
- Duplication of therapy
- Prescriptions that exceed the Federal Drug Administration (FDA) daily or monthly quantity limits
- Non-formulary brand-name drugs when an equivalent generic exists on the formulary
- Drugs that have a step edit and the first line of therapy is inappropriate or already tried and failed
- Drugs that have an age limit
- Multi-ingredient compounds
- All biological and biosimilar agents
- Infusion and enteral therapy request from a non-participating vendor

- All special needs infusion therapy or enteral feedings that need to be customized for the enrollee
- Prior Authorization for Opioids- In alignment with Florida's Opioid State Targeted Response Project, FCC will implement formulary changes affecting opioid prescriptions.

Mental/Behavioral Health/Substance Use Disorder

Florida Community Care manages mental and behavioral health services for Florida Community Care Enrollees with DSM-5 diagnoses. FCC 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. Services include:

- Residential treatment
- Acute inpatient hospitalization
- Partial hospitalization
- Intensive outpatient services
- Electroconvulsive therapy (ECT)
- Assertive community treatment (ACT) services
- Psychological testing

Physical Medicine and Mental/Behavioral Health / Substance User Disorder Integration

Mental and behavioral health (MBH) and physical [medical and surgical] medicine (PM) services are typically delivered by different providers in separate settings, often with little coordination or integration. This fragmented delivery of care is particularly problematic for Enrollees with serious mental illness (SMI) because of their mental health needs and often significant physical co-morbidities that further complicate their health status.

Florida Community Care efforts to integrate MBH and PM to assist its Enrollees is strengthening the relationships between physical, mental, and social factors and high rates of comorbid illness that can increase improved outcomes for FCC Enrollees. FCC actively supports its primary care providers and MBH providers to work collaboratively on this effort.

Obtaining a Prior Authorization

A PA is obtained directly online on FCC's Provider Portal, by calling the Utilization Management Unit directly (1-833-322-7526, then press 2), email or by faxing in the request (305-675-6138). In the event that the online service is off-line, or the provider's online service is off-line, FCC offers telephone and FAX submissions.

FCC's prior authorization process is rooted in evidence-based physical medicine and surgical practices, current pharmaceutical therapies, and evidence-based mental and

behavioral health practices. All providers submitting a prior authorization must submit the clinical information and must cite the source of the medical necessity by means of a clinical guideline, criteria set, or medical policy as set up by the Centers for Medicare and Medicaid or by the AHCA. Providers will not be given criteria to follow as part of the prior authorization process.

Non-emergency Transportation

Florida Community Care has contracted with several providers to offer non-emergency transportation (NET) to Florida Community Care Enrollees that have the MMA benefit. The majority of FCC Enrollees have the MMA benefit. You should always check the Enrollees benefits before ordering non-emergent transportation. The Enrollee's FCC Care Managers can assist in the coordination of this transportation. Physician, providers, and Enrollees can call 1-833- FCC-PLAN.

Pharmacy Benefits

CVS as FCC's Pharmacy Benefits Manager

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 via its CVS Pharmacies and its network of other participating local community pharmacies. This is for both point-of-sale in-store counter pickup, mail order, and over the counter (OTC) benefits. Providers and Enrollees with questions should contact check the FCC website for participating pharmacies in their local area or go to any CVS Pharmacy or call 1-833-FCC-PLAN for assistance.

FCC's Preferred Drug List

Florida Community Care's Preferred Drug List (PDL) formulary is issued directly by the Agency for Health Care Administration (AHCA), which also has the prior authorization listed, step therapy requirements cited, and dispensing limits indicted. This is a closed formulary and only reflects what the Agency has delineated for coverage, which means that not all drugs are covered nor is the PDL reflective of a "generic first" utilization. Thereby, all participating providers must adhere to the AHCA PDL and the PDL requirements when prescribing drugs for FCC Enrollees.

Providers prescribing drugs not on the PDL or want to request an exception to the four restricted categories: not normally covered or to step therapy or prior authorization or those drugs that have stated quantity limits may do so by contacting FCC's PBM, CVS at 1-877-888-8347.

Pharmacy Benefit Limitation related to what AHCA defines them to be and can change without prior notice from AHCA or FCC. Please check the AHCA website on a regular basis for updates and changes and their associated implementation dates. Website: U:\Pharmacy Services\AHCA PDL\Florida Medicaid Preferred Drug List (PDL).htm

Over-the-Counter Expanded Benefit

Florida Community Care has expanded its pharmacy benefit by including over the counter (OTC) drugs, supplies, and personal items. There is a \$25 per family per month OTC limit to this expanded benefit. A catalog of available items can be found on the FCC website at www.fcchealthplan.com to access the OTCHS catalog or by calling 1-888-628-2770; TTY: 1-877-672-2688 or go directly to the order online at www.fcchealthplan.otchs.com.

CVS Pharmacy Network FCC's network of participating pharmacies includes all of the CVS Pharmacies nationwide along with many other regional and local pharmacy, such as Publix, Walmart, and CVS/Target. Please check the FCC website for details or contact CVS at for details and questions.

HearUSA (Hearing)

Florida Community Care has contracted with Hear USA 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.

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

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:

FCC Managed Medical Assistance Expanded Benefits

Service	Description	Coverage/ Limitations	Prior Authorization
Acupuncture	Acupuncture is a form of alternative medicine in which thin needles are used	A professional certified in Acupuncture can provide up to 48 units (15 minutes per unit) per year	Yes
Biometric Equipment	<ul style="list-style-type: none"> Blood pressure monitor Weight scale 	All enrollees eligible <ul style="list-style-type: none"> 1 digital blood pressure cuff every 3 years 1 weight scale every 3 years 	Yes
Cell phone services	1 cell phone; 350 minutes; unlimited text messages;	All enrollees eligible If enrollee has no current cell phone. Also, if there is only limited service.	Yes
Chiropractic Services	Diagnosis and manipulative treatment of the joints, especially the spine	Up to 28 more visits	Yes
Doula Services	Birth coach who helps women during pregnancy	All enrollees Unlimited as authorized on enrollee's plan of care	Yes
Durable Medical Equipment/ Supplies	One box fan	For enrollees 21 years of age and older One box fan per year if they do not have air conditioning where they live.	Yes
Financial Literacy	Life coaching for money management/ budgeting; Access to financial vendor for investment guidance, financial counseling, more financial consults, advice, tax consultation and a 25% discount on tax preparation and credit repair; Unlimited	For MMA-only enrollees Unlimited	Yes
Flu/Pandemic Prevention Kit	One Flu Kit: <ul style="list-style-type: none"> 3 ply face masks - 10 piece Oral Digital Thermometer 	Eligible for the first 1,000 enrollees who have received	No

Service	Description	Coverage/ Limitations	Prior Authorization
	<ul style="list-style-type: none"> Hand Sanitizer 	their flu vaccine. (Must be requested by case manager.)	
Group Therapy (Behavioral Health)	Services for a group of people to have therapy sessions with a mental health professional	For MMA only enrollees Unlimited as authorized on enrollee's plan of care	Yes
Hearing Services - expanded	Services to help with hearing loss	For enrollees 21 years of age and older <ul style="list-style-type: none"> Assessment for hearing aid Hearing aid fitting/ checking Hearing aids Hearing aid evaluation 1 every 2 years; except for a hearing aid in a single in ear, which is 1 per year.	No
Home Delivered Meals (General)	Meals delivered to the home as needed	For MMA-only enrollees Unlimited as authorized on enrollee's plan of care.	Yes
Home Delivered Meals – Disaster Preparedness/ Relief	One shelf-stable meal package (10 meals) per disaster	For all enrollees in an affected area with Governor declared state of emergency.	Yes
Home Delivered Meals – Post Facility Discharge (Hospital or Nursing Facility)	Meals delivered to the home as needed	For MMA-only enrollees Unlimited as authorized on enrollee's plan of care	Yes
Home Health Nursing/Aide Services	Home based care as needed in the enrollee's plan of care.	For MMA-only enrollees Unlimited as authorized on enrollee's plan of care.	Yes
Home Visit by a Clinical Social Worker	Clinical social worker visit as need in the enrollee's plan of care.	For MMA-only enrollees Unlimited as authorized on	Yes

Service	Description	Coverage/ Limitations	Prior Authorization
		enrollee's plan of care	
Housing Assistance	Housing help for when moving from a nursing home to an assisted living facility.	All enrollees \$1,000 per lifetime	Yes
Legal Guardianship	Members who are in a SNF or PDN setting, and a parent is obtaining guardianship to protect individuals who are unable to care for their own well-being.	Enrollees age 17 to 18.5 \$500 per eligible enrollee per lifetime	Yes
Individual/Family Therapy	Services for people to have either one-to-one or family therapy sessions with a mental health professional	For MMA only enrollees Unlimited as authorized on enrollee's plan of care	Yes
Meals-Non-Emergency Transportation Daytrips	Allowance to cover the cost of food for long distance trip.	All enrollees Up to \$20 per trip in excess of 100 miles as authorized on enrollee's plan of care	Yes
Medically Related Home Care Services/ Home Maker	Example: 2 carpet cleanings per year for adults with asthma	For MMA-only enrollees Unlimited as authorized on enrollee's plan of care	Yes
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	All enrollees Unlimited as authorized on enrollee's plan of care	Yes
Nutritional Counseling	Nutritional counseling as needed in the enrollee's plan of care.	For MMA-only enrollees Unlimited as authorized on enrollee's plan of care	Yes
Occupational Therapy	Services to help with pain, gain or bring back physical functioning and movement	For enrollees 21 years of age and older <ul style="list-style-type: none"> • One evaluation per year • One reevaluation per year • Up to 7 treatment visits per week 	Yes

Service	Description	Coverage/ Limitations	Prior Authorization
Outpatient Hospital Service	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	For MMA-only enrollees Unlimited as authorized on enrollee's plan of care	Yes
Over the counter (OTC)	<ul style="list-style-type: none"> • Cough and cold allergy medicines • Vitamins • Medicines for the eyes • Pain medicine • Products for the stomach and bowel • First aid care • Hygiene products • Mosquito spray • Mouth and teeth cleansing products • Skin care 	All enrollees eligible (18 years of age and older) Up to \$25 per month OTC Catalog available upon request	No
Pet Therapy	Activity therapy with a pet as needed in the enrollee's plan of care.	All enrollees Unlimited as authorized on enrollee's plan of care	Yes
Physical Therapy	Services to help with pain, gain or bring back physical functioning and movement	For enrollees 21 years of age and older <ul style="list-style-type: none"> • One evaluation per year • One reevaluation per year • Up to 7 treatment visits per week 	Yes
Prenatal/Perinatal Visits - Expanded	Prenatal and after birth care including breast pumps visits to see doctor during pregnancy and after	For enrollees 18 years of age through 59 <ul style="list-style-type: none"> • Hospital type breast pump (1 rental per year) • Standard breast pump (1 rental every 2 years) • 14 visits for low-risk pregnancies • 18 visits for high-risk pregnancies • 3 visits within 90 days following delivery 	No
Primary Care Services	Well or sick visits to see your PCP	Unlimited office visits	No

Service	Description	Coverage/ Limitations	Prior Authorization
Respiratory Therapy	Services to treat problems with the lungs	For enrollees 21 years of age and older <ul style="list-style-type: none"> • One initial therapy evaluation per year, per enrollee • One respiratory therapy visit, one per day 	Yes
Speech Therapy	Services to help with the voice and to talk and swallow	For enrollees 21 years of age and older <ul style="list-style-type: none"> • Evaluation/reevaluation, one per year • Evaluation of swallowing, one per year • Speech therapy visit, up to 7 therapy treatment units per week • Augmentative Alternative Communication (AAC) initial evaluation, one per year • AAC reevaluation, one per year • AAC fitting, adjustment, and training visit, up to four 30-minute sessions per year 	Yes
Substance Abuse Treatment or Detoxification Services (Outpatient)	Substance abuse treatment or detoxification services provided in an outpatient setting (not staying overnight)	All enrollees Unlimited as authorized on enrollee's plan of care	Yes
Swimming Lessons (Drowning Prevention)	Help with swimming for children	For MMA enrollees only ages 18-20 Unlimited as authorized on enrollee's plan of care (space is limited)	Yes

Service	Description	Coverage/ Limitations	Prior Authorization
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 18-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	For MMA enrollees only ages 18-20 Up to 9 hours per month as authorized on enrollee's plan of care	Yes
Transportation Services to Non-Medical Appointments/Activities	Transportation for non-medical trips, such as shopping or social events	For all enrollees One round trip per month, under 15 miles	Yes
Tutoring K-12	Tutoring services for members in kindergarten through 12th grade	For enrollees ages 5-19 Two hours per week	Yes
Vaccine- Influenza	Flu Vaccine	For all enrollees Annual	No
Vaccine- Shingles	Shingles Vaccine	For all enrollees One per year with prior authorization	No
Vaccine- Pneumonia	Pneumonia Vaccine	For all enrollees Unlimited with prior authorization	No
Vaccine-TDaP	Tetanus, Diphtheria, Pertussis Vaccine	For all enrollees <ul style="list-style-type: none"> Once per lifetime Booster every 10 years 	No
Vision Services- Expanded	Eye care services that include eye exams	For enrollees 21 years of age and older <ul style="list-style-type: none"> Contact lenses – 6- month supply Eye exam – one per year Frames – one per year 	No

Service	Description	Coverage/ Limitations	Prior Authorization
Waived Co-Payments	Members will not need to pay any co-payment charges	No benefit will have a co-payment	No

FCC Long Term Care Expanded Benefits

Service	Description	Coverage/ Limitations	Prior Authorization
ALF Move in Basket	Members can select up to \$50 worth of items	LTC enrollees currently living in an ALF and new members transitioning/moving into an ALF. \$50.00 one lifetime benefit	No
Assisted Living Facility/Adult Family Care Home – Bed Hold Days	Bed will be held while away sick at a hospital or rehab place	LTC enrollees that are in ALF or AFCH Up to 31 bed hold days per month	No
Caregiver Transportation	Four (4) one-way trips (for caregivers) monthly to visit a member who is residing at an ALF	For LTC eligible caregivers who need transportation to see loved ones in an ALF. Four one way trips a month	No
Individual Therapy Sessions for Caregivers	Therapy for caregivers as needed in the enrollee's plan of care	All enrollees Up to 12 hours per year	Yes
Healthy Living Benefit	Healthy lifestyle aids to help members stay independent at home	LTC only enrollees One lifetime benefit Members can select two items: <ul style="list-style-type: none"> • Digital scale • Home blood pressure cuff • Peak flow meter • Reachers/ grabbers • Lumbar pillow • Personal fan • Clip-on lamp • Walker bag • Face mask (2) 	No
Transition Assistance– Nursing Facility to Community Setting	Pays for certain expenses if an enrollee moves from a nursing home to the community	LTC enrollees that are not HCBS	Yes

		\$5,000 per transition	
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FCC's expanded benefits may be changed on an AHCA or FCC benefit contract year in a manner and format approved by AHCA, if determined to be beneficial to the Enrollees.

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 Service 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.A.Q.C, FCC offers Telemedicine Services to its Enrollees.

Telemedicine is the use of electronic information and telecommunication technologies the practice of health care delivery by a practitioner who is located at a site other than the site where the enrollee is located for the purposes of evaluation, diagnosis, or treatment.

FCC Enrollees can access services through participating telemedicine providers. 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 unauthorized access to the system or information.
- System security, including the integrity of the information that is collected, program integrity and system integrity; and

- Maintenance of documentation about system and information usage.

When billing for telemedicine services, Telemedicine providers must bill with the correct telemedicine modifiers: CR for Audio only; and GT for Audio / Video.

Providers are required to follow all contractual requirements that apply to face-to-face visits / encounters, including maintenance of medical records, when conducting Telemedical visits.

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. As FCC only provides MMA and LTC benefit for children between the ages of 18 to 20, the service provided under this benefited are limited to those associated with children in this age group.

Thereby, FCC provides coverage for any associated 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)) associate with the EPSDT screening criteria. All request for covered and non-covered services are still applicable for medical necessity [prior authorization] review in order to obtain approval.

In accordance with the statute, 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 18 through 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 in place for authorization services associated under the EPSDT 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.

The associated claims that meet all the requirements of EPSDT screening services 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 a 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.

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.

Utilization Management Within the FCC Case Management/Coordination 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.

As previously cited, there are two types of authorization processes:

- Service Authorization (SA)
- Prior Authorization (PA)

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 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.

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
- 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 helpline, 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 responds 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 is available to non-clinical authorization representatives during authorization intake for any questions. Non-clinical staff informs 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 collects 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.

Defining Medical Necessity

Please take note that the definitions for medical necessity are different under MMA benefits and LTC benefits. The two are not interchangeable. Make sure that you familiarize yourself between the two to assure that you are establishing the correct guidelines for each program. The definitions for medical necessity are established by the Agency for Health Care Administration (AHCA). These are not FCC definitions.

Defining Medical Necessity for Long Term Care (LTC) Services

FCC reviews LTC and for medical necessity in compliance with the AHCA Contract and AHCA Rules. 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.

Defining 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 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.

Authorization Processes

There are two different authorization types:

1. Prior Authorization (PA), which is part of FCC’s Utilization Management services for MMA program
2. Service Authorization (SA), which is part of FCC’s Home and Community Based Services for the LTC programs

Note: *These two authorization types are completely different from one another and have separate requirements.*

As cited above, FCC’s prior authorization process applies to a single episodic request such as elective hospitalizations and medical procedures, request for durable medical equipment or request for continuation of services, such as outpatient therapy services. As the name implies, all requests need to be obtained and approved prior to the service being rendered or the product issued. 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 accurate and timely reimbursement for the provider.

Prior authorization is a three-step process. Intake of the case into the FCC system either through the FCC portal, email, fax or call into an UM Coordinator. A registered nurse then processes every request as the source of a primary clinical review verifying for medical necessity. When a primary nurse reviewer is unable to decide the medical necessity of the request, the nurse looks to discuss the case with the requesting provider. Should that not prove medical necessity by the AHCA definition, the case is referred to the Medical Director for secondary 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 decides 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, the Medical Director forwards the case back to the primary review nurse to process the determination. When the determination is adverse, the Medical Director documents the rationale for the determination and then produces an AHCA approved Notice of Adverse Benefit Determination (NABD). The letter is sent to the nurse who originally sent the case to the Medical Director and performs a Quality Assurance check on the letter. Upon passing that review, the nurse processes the NABD letter for mailing to the Enrollee with a copy also sent to the requesting provider.

The nurse then contacts the provider's office by phone to provide verbal notification of the adverse benefit determination. The nurse advises the requesting provider that the provider has a 45-day reconsideration period for a review of the case with any new or additional information or documentation or to request a peer-to-peer dialogue with the FCC Medical Director.

This process is not in lieu of filing an Enrollee appeal but is a step that can be used to resolve the adverse determination instead of moving right to the appeal process. It is only after the 45-day reconsideration process does the Enrollee have the ability to file an appeal.

Should you not want to file a reconsideration and move straight to appeal, you can do so only with the signed and dated authorization from the Enrollee. The 45-days reconsideration process allows for an appeal like process with the exception of the fact that the same FCC Medical Director will be re-reviewing the submission. In the Appeal process, a completely different FCC Medical Director or clinical surrogate reviews the appeal.

Concurrent Review

Concurrent Review is the process of evaluating admissions and continued stay requests when an Enrollee is hospitalized in an acute, skilled nursing or acute rehabilitation facility. Here, primary review staff review all emergent admissions for medical necessity, reasonableness or appropriateness 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.

Hospital Observation

Emergency cases that require observations, but do not require inpatient admissions are addressed in accordance with the CMS "Two-Midnight Rule," as both a clinical and business practice. These cases do not require authorization for the observation/stabilization period (up to 48 hours). Admission to the hospital and/or continued stay beyond the anticipated 48-hours will require prior authorization just like any other emergency admission.

Out-of-Network Requests for Non-Emergency Services

There will be times when an Enrollee may need the services of an out-of-network provider or vendor. Enrollees and referring providers or the out-of-network provider or vendor can submit a request with FCC's UM Department utilizing the FCC portal or via email, phone, or fax to make the request for an out-of-network provider or vendor.

Written documentation to support the clinical need and the establishment of medical necessity is required. There must be a clear and definitive rationale for why the service or vendor service cannot be provided by an in-network provider or vendor. Once the documentation and information are received by FCC's UM Department and found to be complete, a decision will be made within one (1) business day from the completed request.

Note: *The Enrollee will be financially liable for the cost of unauthorized services from non-participating providers and vendors. Thereby, please do not encourage Enrollees to pursue out-of-network services or products to have the utilization reviewed retrospectively. FCC does not do retro-reviews of out-of-network/non-participating services or products on an elective basis. The only retro-review allowed will be in emergent.*

Authorization of Long-Term Care (LTC) Services

The Service Authorization (SA) process for LTC services encompasses the following program components:

- person-centered assessment
- service planning
- medical necessity review

FCC conducts a comprehensive assessment of the Enrollee prior to the development of the initial Plan of Care (POC). FCC reviews and utilizes AHCA-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 CM 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 provider (PCP), and the Interdisciplinary Care Team and its members. The process is complete when a service determination has been made and communicated appropriately to the Enrollee.

Each LTC Enrollee is assigned a Care Manager (CM) as his or her point person to ensure that the Enrollee needs are identified, and services are coordinated in a timely and appropriate manner. The CM to Enrollee ratio is 1:60. The CM and the rest of the team work to coordinate the case of each Enrollee. The CM or FCC does not manage care. Our role is to assist in the facilitation of care coordination to the right level of service, at the right time, to the right provider. CMs collaborate with treating providers and take every means to cooperate with the caregiver needs.

For specific LTC Home and Community Based Services (HCBS) requiring service authorization requires information that is collected from the Enrollee, the Enrollee's caregiver and the Enrollee's PCP and other providers involved in the Enrollee's care and

treatment. FCC CMs complete the 701B and Health Risk Assessment as part of the review process.

LTC CM are able to authorize, 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,
- durable medical equipment under \$500
- transportation services

When the FCC CMs 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.

If an Enrollee requires an MMA service reviewed prior authorization, the CM works with the UM team to facilitate review of the requested service.

Face-to-Face Completion of the LTC the Plan of Care (POC) Service Authorization (SA) Process

FCC CMs 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.

When an FCC CM is unable to reach an Enrollee to complete the 701B and then the POC, the CM will follow the FCC policy and procedure for “unable to reach” to locate the Enrollee.

When the Enrollee has services already in place through a prior plan of care from a prior LTC plan, the Florida Medicaid Continuity of Care (COC) [See below for details] process will be invoked, and the existing services will be authorized until the Enrollee can be reached.

When 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 CMs 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 CMs 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 CM 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 than 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.

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.

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. In the event that the Enrollee seeks to consult with his or her PCP for assistance on seeking out a second opinion, the Enrollee is free to do so, as long as the selection by the PCP is within the FCC participating network. Any choice by either the Enrollee or the PCP to utilize an out-of-network provider is permissible, but FCC shall only provide payment coverage to the provider in the amount of all charges being consistent with usual, reasonable, and customary fees in the regional community, for second opinion services FCC may require that any tests requested by a non- participating provider be conducted by a participating in-network provider or vendor.

Retrospective Review

Retrospective review is the process of completing a medical necessity review after a service has already been started 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 (urgent or emergent), or the Enrollee's primary insurance eligibility being FCC was misidentified. Prior to completing a retrospective review, the prior authorization nurse confirmation of the Enrollee's eligibility and benefits at the time the service was initiated or rendered is verified. Only those Enrollees that have eligibility and benefits related to the service or product will be reviewed. All others will be denied coverage based on non-eligibility and/or no benefit coverage.

All retrospective requests are reviewed in the same manner as any prior authorization request for medical necessity. When considering a retrospective authorization request, the primary reviewer reviews information that was submitted or made available at the time the service was initiated or rendered, or product initiated. The case is referred to the Medical Director for review if medical necessity is not established. The Medical Director

reviews all available clinical information and can obtain a peer-to-peer discussion or seek to obtain more information or clarification in the case in order to decide the medical necessity of the case. Once the Medical Director decides, the case is processed in the same manner as cited above for both approvals and adverse determinations.

Notice of Certification

When a case is approved, the case is issued a Notice of Certification (NOC) as valid proof for the Enrollee and requesting provider. This certification can be via written in the form of an e-mail or fax or verbally by 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 an Approval

FCC does not reverse an approval unless staff receives new information relevant to the request that was not available at the time of the original determination.

Discharge Planning and Transition of Care

Discharge Planning (First Step to Transitioning Care)

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 a 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 process includes the nurse that had reviewed the case concurrently, the CM, the hospital discharge planner, the Enrollee's primary care physician, other treating providers, the Enrollee, and the Enrollee's family or representative or designated caregiver.

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 to pursue an active course of treatment that was established upon discharge. This is considered a “transition period.” The transition period is that time in-between when an Enrollee moves between episodes of care. Typically, the period prior to when the Enrollee has to obtain a follow-up visit with his or her PCP or other providers, go for diagnostic testing or therapies. This period is closely monitored by FCC CM or Clinical Care Specialist.

Continuity of Care (COC) Provision Requirements

COC requirements ensure that when Enrollees transition from one health plan to another, one service provider to another, or one service delivery system to another (i.e., fee-for-service to managed care), their services continue seamlessly throughout their transition. The Agency has instituted the following COC provisions:

- **Health care providers should not cancel appointments with current patients.** Health plans must honor any ongoing treatment that was authorized prior to the recipient’s enrollment into the plan for up to 60 days after the roll-out date in each region.
- **Providers will be paid.** Providers should continue providing any services that were previously authorized, regardless of whether the provider is participating in the plan’s network. Plans must pay for previously authorized services for up to 60 days after the roll-out date in each region and must pay providers at the rate previously received for up to 30 days.
- **Providers will be paid promptly.** During the continuity of care period, plans are required to follow all timely claims payment contractual requirements. The Agency will monitor complaints to ensure that any issues with delays in payment are resolved.
- **Prescriptions will be honored.** Plans must allow recipients to continue to receive their prescriptions through their current provider, for up to 60 days after the roll-out date in each region, until their prescriptions can be transferred to a provider in the plan’s network.

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 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 is not required.
- Frequency of request for Enrollees--if a service or item is frequently requested for Enrollees that a service authorization is not 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 a service authorization.

Fraud, Waste, and Abuse Reporting

FCC employs a formal under and overutilization 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/mpicomplaintform/> or by calling the Agency hotline at 1-888-419-3456.

Utilization Management Criteria

Clinical Decision Guidelines for MMA and Specified LTC Services

Florida licensed clinical 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, and a cadre of nationally recognized source such as, but not limited to the American College of Physicians, American Academy of Family Practice, American College of Obstetrics and Gynecology, American Cancer Society, and the American College of Surgeons.

The Chief Medical Officer submits the clinical guidelines annually to the Utilization Management Committee and then up to the Quality Improvement Committee for review and approval.

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 uses 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 the home, Care Managers use 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 the 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 the application of the tool. If the Care Manager believes fewer hours should be authorized than are recommended, a Medical Director reviews the request.

When authorizing LTC services other than personal care, the FCC Care Managers utilize AHCA and federally established and published guidelines to approve or adversely determine a covered service.

UM Timeliness

Pre-service Standard Requests

Staff process pre-service routine requests within 7 calendar days from the date of receipt. 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

Staff process pre-service urgent requests within 48 hours from the date and time of receipt. 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

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, 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

CMs complete all authorizations for LTC services within their scope of authority within 24 hours from the Enrollee's assessment.

Retrospective Reviews

Staff process retrospective review requests within 30 calendar days from the date receipt. staff provides electronic or written notification of the decision to providers and Enrollees within 30 days from the date of receipt.

Peer-to-Peer Reconsiderations

Staff notifies providers of the right to request 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 staff follow the adverse determination process including notifying the provider of appeal rights.

Authorization Extensions

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. Staff notifies 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 (NABD)

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 are 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 payments of services.

For service authorization decisions not reached within required timeframes, or the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.

45-Day Reconsideration Process Following an Adverse Determination

FCC offers a 45-day reconsideration period for a requesting provider to request a re-review of a case that was just issued an adverse determination. This option is available for 45-days from the date of the Notice of Adverse Determination (NABD).

The reconsideration process involves both the same primary nurse reviewer that screened the original case and the medical director that issued the adverse determination.

THIS IS NOT JUST A RE-REVIEW OF THE CASE. The requesting provider must submit any additional or missing clinical documentation or offer new information that was inadvertently omitted from the original submission.

The requesting provider can also choose to request a peer-to-peer discussion with the medical director over or in addition to submitting additional documentation or instead of submitting clinical information in order to discuss the clinical information that was submitted in the original request.

Depending upon the clinical information submitted or discourse had, a re-determination to stay the original determination or overturn it will be made. In the scenario where the adverse determination is upheld, both the Enrollee and the requesting provider will be notified, both verbally and in writing, that the reconsideration yielded an uphold of the original determination. When overturned, the Enrollee and provider will receive a verbal notification that the reconsideration yields an overturn approval.

When a reconsideration is upheld, the Enrollee and/or the requesting provider, undersigned and dated authority by the Enrollee may submit a request for an Enrollee Appeal under the Agency's approved process. Please note that requesting providers are not permitted to appeal an Enrollee clinical case without signed authorization from the Enrollee.

Appeal Process

FCC permits an Enrollee, an Enrollee's authorized representative, or a professional provider acting on behalf of an Enrollee to appeal coverage decisions via a signed and dated authorization from the Enrollee. Under no circumstance shall an appeal be entertained by a professional provider that is without authorization from the Enrollee.

The NABD 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 professional 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 process is similar to that of the initial PA process, but it does not involve the same reviewers. The reviewer is new to the case reviewing it for the first time. The case is sent to an Appeal nurse reviewer for initial review to check for any errors that would have been made in the original determination. The case is written up by the Appeal nurse who compiles all of the necessary documentation and submits everything to FCC's Independent Review Entity (IRE) for review and disposition. This is truly an independent entity with a medical reviewer that will review the appeal with an unbiased review. Determinations made by an IRE medical review agent are done against all available clinical information, evidence-based clinical criteria, and guidelines; and, under Florida Medicaid Coverage Policy.

Once the IRE medical reviewer completes the review, he or she shall 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 IRE medical reviewer reaches a determination on the appeal, the appeal case is processed to submit a written notification to the Enrollee of the adverse determination made in the case.

When the IRE medical review agent's determination is to overturn the original Plan determination, the Appeal nurse overturns the original denial in the system and places it in an approved status. The Enrollee and requesting provider are notified verbally of the overturn. The Enrollee is then issued a Notice of Plan Appeal Resolution (NPAR) within five (5) days of the determination.

In the case of an expedited appeal, the request for the expedited appeal must meet Florida Medicaid's definition for it to be expedited. All expedited requests that do not meet the definition, FCC shall convert to a standard appeal.

An expedited request can be 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 criteria 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 maintains 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

Disease Management

The unique feature of both programs is that FCC does not consider these standalone programs as do the MMA or Medicare Part C plans. We have integrated these programs directly into our Case Management Care Coordination process. Our belief is that these processes go hand-in-hand and better handled through the single case management/care coordination process when it comes to LTC.

When you think about LTC you should think of a continuum of programs woven together to create one process that addresses all problems together and not separately. Condition- specific interventions and programs focus on the improvement of specific clinical conditions and promote continuous quality improvement for our Enrollees. Providers are encouraged to collaborate with us to close gaps in clinical care. This can be done by referring Enrollees with chronic conditions into our Disease Management Programs, where they will receive condition-specific coaching and education related to their condition.

When we talk Disease Management we are talking about 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 Care 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 perfect our disease management intervention by leveraging all resources available to the Enrollee.

FCC gives interventions which range from educational information for both the provider and Enrollees to disease management training from our Care Managers to better empower Enrollees. Enrollees will receive different levels of interventions found by the disease risk level or need.

Core components of the FCC Case Management/Care Coordination process include collaboration between PCP, behavioral health provider (when applicable) and specialty providers and is essential to support and provide both the appropriate level of care and continuity of care. Our Care 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 proper 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, more Care 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.

Emergency Services

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 enough 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.

Upon stabilization of the emergency condition, the provider must seek authorization for any continued and ongoing care.

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

There are no referrals necessary for any Enrollee in Florida Community Care when the referral is to an in-network participating professional provider, facility, servicing provider, or vendor. Prescriptions are necessary when applicable. Prior authorizations are necessary for any professional provider, facility, servicing provider, or vendor. Use of a non-participating entity will not be covered by FCC, nor will they be retroactively reviewed for coverage. The liability will be that of the non-participating provider and the Enrollee.

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 a 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.

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.

Additionally, for DME Providers, FCC uses a DME Formulary for services that have been authorized to DME Providers servicing FCC members. To view the Formulary (including our *MMA/LTC and our **LTC only procedure codes & description of services) covered by our plan, please go to FCC's website at www.fcchealthplan.com and reference the For Providers section of the website; specifically, the DME Resources subsection.

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.

The 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 the timeliness of filing and processing claims.

Inpatient Interim Billing Process

Hospitals can submit interim bills for inpatient admissions that exceed 100 days. These interim bills should not include a discharge date but should include the admit date to the date of the interim bill. The claim should be submitted with a bill type of 0112 (interim bill-first claim) and a patient status code of 30. Subsequent interim bills should be billed with bill type 117 (corrected claim) and patient status of 30, or if final bill, then the discharge patient status. Each claim should include all diagnoses and procedures applicable to the admission.

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. 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 an 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.

J Code Drug Unit Billing

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 Required for J Code Billing

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 are Required for J Code Billing

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."

Medicare Crossover Payments / Coordination with Medicare Advantage Plans

FCC follows CMS Guidelines and Florida Statute 409.908 (13) when processing Medicare Crossover payments or Coordinating benefits with MA plans.

If the FCC member has Medicare (not Medicare Advantage) as primary, then as a provider you do not need to submit a claim to Florida Community Care. We will automatically receive the claim as a crossover claim from Medicare directly. Once we have received the crossover claim, we will review the coordination of benefit rules and process any amounts due to you as a provider.

If the FCC member has a Medicare Advantage plan as primary, FCC would be the secondary payer. As a provider you are required to submit the claim to the respective Medicare Advantage plan first and then submit your Claim with Remittance from the primary Medicare plan to Florida Community Care. You can submit the Claim electronically and enter the primary payer payment information to the COB segment on the 837; or send a Paper Claim with the Remittance to FCC at:

Florida Community Care
Attn: Claims
P.O. Box 211322
Eagan, MN 55121

Please remember that Medicaid is secondary and will generally not pay more than the Medicaid allowable. Therefore, if Medicare, or a Medicare Advantage Plan has paid greater than the Medicaid allowable, then no secondary payment is due to a provider, pursuant to Florida Administrative Code 59G-1.052(8)(b)1. Please be sure to fully process the claim with both Medicare and FCC before reaching to the enrollee for payment.

Please see the following examples from the Statewide Medicaid Managed Care Requirements for Reimbursement of Nursing Facility Medicare Part A Coinsurance Claims:

Example 1

Medicare paid \$2,200 (after the coinsurance is subtracted) for 10 days. This calculates out to \$220 per day.

FCCs per diem for this nursing facility is \$200 per day. The Medicare payment exceeds the facility's per diem rate.

FCC owes \$0 coinsurance payment.

The enrollee's patient responsibility amount is \$0, and FCC would pay the nursing facility claim \$0, because no payment amount is due.

Example 2

Medicare paid \$2,200 (after the coinsurance is subtracted) for 10 days. This calculates out to \$220 per day.

FCCs per diem for this nursing facility is \$225 per day. The Medicare payment is less than the facility's per diem rate.

Medicaid owes $\$5 \times 10 \text{ Days} = \50 total coinsurance payment.

If the enrollee is QMB eligible, the patient responsibility amount is \$0 and FCC would pay the nursing facility claim at \$50. If the enrollee is not QMB eligible, see example 3.

Example 3

Medicare paid \$2,200 (after the Medicare Part A coinsurance is subtracted) for 10 days. This calculates out to \$220 per day.

FCCs per diem for this nursing facility is \$225 per day. The Medicare payment is less than the facility's per diem rate.

FCC owes $\$5 \times 10 \text{ Days} = \50 total coinsurance payment.

The enrollee is not QMB. The enrollee has a monthly patient responsibility of \$500

The nursing facility collects \$50 of the 10 days pro-rated patient responsibility from the enrollee and FCC would pay the nursing facility claim at \$0.

Example 4

Medicare paid \$2,200 (after the Medicare Part A coinsurance is subtracted) for 10 days.

This calculates out to \$220 per day.

FCCs per diem for this nursing facility is \$235 per day. The Medicare payment is less than the facility's per diem rate.

FCC owes $\$15 \times 10 \text{ Days} = \150 total coinsurance payment.

The enrollee is not QMB. The enrollee's pro-rated patient responsibility for 10 days is \$125.

The nursing facility collects \$125 of the patient responsibility from the enrollee and FCC would then pay the nursing facility claim the additional \$25.

Note: *The amount of the enrollee's patient responsibility is zero during nursing facility Medicare Part A coinsurance days if the enrollee is QMB eligible or if the amount of the Medicare Part A coinsurance amount that Medicaid owes per day is less than or equal to \$0.*

If Medicaid owes any amount of a nursing facility Medicare Part A coinsurance per day and the enrollee is not QMB eligible, the amount of the difference owed can be taken from the patient responsibility up to the total amount owed. If the patient responsibility does not totally pay the amount owed, the difference can then be paid by the SMMC plan.

SMMC plans, and nursing facilities cannot collect any amount of patient responsibility that is in excess of the amount applied to the provider's payment.

Please follow the Medicare and Medicaid guidelines for Coinsurance Billing.

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 advices 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 a 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) 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.

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
- 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 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 the overpayment, to the extent permitted by applicable law, including but not limited to, by offsetting against future claim 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 being changed.
- Upon receipt of the refund letter, follow the steps outlined in the above Florida Community Care Identified Overpayments section.

Option 2: Refund the Overpayment

- 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 issued check.
- Mail a check and any supporting documentation such as correct claim, remittance advice to:

Florida Community Care
Attn: Claims – Overpayment
P.O. Box 211322
Eagan, MN 55121

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.

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.

Provider Complaints

Non-Claims Related Complaints

Providers submitting complaints concerning non-claim issues shall have (45) days to file their written complaint. These include any complaint, including clinical issues, with the exception of filing a clinical appeal as the provider or on behalf of the Enrollee. 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. Unlike Enrollee complaints, provider complaints do not convert into grievances after one business day of non- resolution of the complaint. FCC will contact the provider verbally or in writing after receiving the complaint. Written complaints can be filed by USPS letter, email, or fax. For purposes of accuracy, FCC does not take verbal complaints. FCC will provide a written notice of complaint status every 15 days thereafter until the Complaint is resolved. FCC will resolve all non-claims provider complaints within (90) days of its documented receipt; and will provide written notice of the disposition to the provider within (3) business days of the resolution date and will include the basis of the resolution.

Claims Related Complaints

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 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 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 an 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
- Email through our provider self-service website: www.fcchealthplan.com
- In writing via U.S. mail to:

Florida Community Care
Attn: Claims Overpayment
P.O. Box 211322
Eagan, MN 55121

Provider Claims 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 Dispute to:

Florida Community Care
Attn: Provider Disputes
P.O. 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 Capitol Bridge, an independent dispute resolution organization, to provide assistance to health care providers and health plans in order to resolve claim disputes.

Capitol Bridge has been accepting claim disputes for Florida's managed care line of business since March 11, 2024. Services offered by Capitol Bridge are available to Medicaid managed care providers and health plans. Claims given to managed care plans that have been denied in full or in part, or allegedly underpaid or overpaid may be eligible for a dispute under the arbitration process.

AHCA contracts with Capitol Bridge to administer this dispute resolution program. You may obtain information regarding the claim dispute resolution process by calling Capitol Bridge toll free at 1-800-889-0549 or email to FLCDR@capitolbridge.com

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 the 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 an Enrollee's family, 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.

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, disabilities, religion, income level, education, geographical location, or profession regardless of sex. 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 Linguistically 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. 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. For more information on the program above, or to access our Cultural Competency Plan, please access our Provider Portal.

Quality Improvement

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/Care 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.)

Nutritional Assessment/Counseling

- FCC ensures that its providers supply nutritional assessment and counseling to all enrollees that have a weight management problem either as being over and underweight.
- FCC ensures the provision of safe and adequate nutrition for all enrollees under the LTC benefit, but only for the non-dual population for enteral feedings and nutritional supplements. Duals get those services provided by Medicare.
- FCC offers a mid-level nutrition assessment to all enrollees.
- FCC provides individualized diet counseling and a nutrition care plan by a nutritionist, a nurse, or physician following the nutrition assessment.

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 Care 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 participate 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

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 a 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 the 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 to acknowledge receipt of audit notification in writing. Said acknowledgment should include at a minimum:

- Contact name and telephone number for the 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 an in-person conference is not required.

- Discussion of the 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 collaborate 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.