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*SFCCN Provider Manual*

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*North Broward Hospital District*

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*1608 SE Third Avenue  
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**SOUTH FLORIDA COMMUNITY CARE NETWORK  
PROVIDER SERVICE NETWORK**

**PROVIDER MANUAL  
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## **WELCOME**

We are pleased to welcome you as a network provider in the South Florida Community Care Network (SFCCN) Provider Service Network (PSN). The South Florida Community Care Network is a partnership formed by the Public Health Trust of Miami-Dade County, the North Broward Hospital District, and the South Broward Hospital District (Memorial Healthcare System) under the Florida Cooperation Act of 1969, F.S. 163.01. Throughout this manual these three health systems will be referred to as “Subnetworks” of the SFCCN.

SFCCN has entered into a contract with the State of Florida Agency for Health Care Administration to provide Medicaid services to eligible Medicaid beneficiaries as a Provider Service Network (PSN). You have chosen to become a provider of this very unique network. Together we will work with you as a team, bringing our individual expertise to achieve the high standards our community expects. The SFCCN’s Provider Service Network (PSN) is a Reform PSN in Broward County, and a non-Reform PSN in Miami-Dade County. Therefore, in Broward County, the North Broward Hospital District and South Broward Hospital Districts are contracted as a Reform PSN, and will therefore provide services required as such.

You have committed to delivering quality medical care to SFCCN enrollees. This provider manual answers many of your questions about the SFCCN and how it works. Outlined in your Provider Manual are the policies, procedures, and programs you have agreed to comply with, as presented in the Provider Services Agreement between you and the South Florida Community Care Network. We are requesting your expertise to ensure that the care provided to the enrollees meets the performance standards and indicators as outlined in your manual. Please review this material to better understand the importance of your role in the provision of services to SFCCN enrollees and compliance with designated program requirements.

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

You are a key part in the inception of this first Medicaid Provider Service Network in the State of Florida. We look forward to a very rewarding business relationship.

# IMPORTANT CONTACTS

PSN Department	Public Health Trust	Memorial Healthcare System	North Broward Hospital District
Provider Relations	305-575-3680	954-276-3131 (prompt #2)	954-767-5640 (prompt #3)
Enrollee Services (Toll free State-wide)	1-877-838-7526	1-866-899-4828	1-866-899-4828
Claims	305-575-3660	954-276-3131 (prompt #3)	954-767-5500
Utilization/Authorization	305-575-3650	954-276-3131 (prompt #4)	954-767-5640 (for inpatient prompt #4, then #1, outpatient prompt #4, then #2)
Adult Psychiatric	1-800-294-8642	1-800-294-8642	1-800-294-8642
Detox/Adolescent Psychiatric	1-800-294-8642	1-800-294-8642	1-800-294-8642
Case Management	305-575-3670	954-276-3131	954-767-5640 (prompt #4, then #3)
Maternal Child	305-575-3667	954-276-3136	954-767-5614
Disease Management	305-585-8070	954-276-3149	954-767-5614

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**Area 11 Medicaid Office/Dade County:**      **Address:** The Kroger Center  
8355 NW 53<sup>rd</sup> Street, 2<sup>nd</sup> Floor, Miami, Florida 33166  
**Telephone No:** 305-499-2000/Fax: 305-499-3997  
**Toll-free number:** 1-800-953-0555

**Area 10 Medicaid Office/Broward County:**      **Address:** 1400 W. Commercial Boulevard, Suite 110, Ft. Lauderdale, Florida  
33309  
**Telephone No:** 954-202-3200/Fax: 954-202-3220  
**Toll-free number:** 1-866-875-9131

**Miami-Dade Non-Emergency Transportation:**      **Dade County:** 305-263-7301 or 305-267-6310 (**during business hours**)  
**After business hours:** 305-471-0911  
**(Call three (3) business days in advance)**

**Broward-Reform (Non-emergency transportation):**      **Broward County:** LogistiCare Reservation Line 24/7 (toll-free 1-866-306-9358)  
Ride Assistance (enrollee): 1-866-306-9359  
**Provider help line:** 1-866-306-9359

**University of Miami Behavioral Health (UMBH):**      1150 NW 14<sup>th</sup> Street, Suite 501 (M861), Miami, FL 33136-2116  
**Telephone No:** 1-800-294-8642  
**TTY/TDD Telephone No (for hearing impaired):** 1-877-520-6254

**State of Florida / Agency for Health Care  
Administration (AHCA) :**      **Address:** 2727 Mahan Drive, Tallahassee, Fl 32308  
**Telephone No:** 1-888-419-3456  
**Website:** [www.fdhc.state.fl.us](http://www.fdhc.state.fl.us)

**ACS (formerly Consultec) Medicaid's fiscal agent:**      **Address:** 2308 Killearn Center Blvd., Tallahassee, Florida 32308  
**Telephone No:** 1-800-289-7799  
**Website:** <http://floridamedicaid.consultec-inc.com>, then enter your provider #

**Medicaid Option Program (Miami-Dade) & Reform Choice Counseling (Broward County):** The entity contracted with the AHCA as the choice counselor to provide all Medicaid beneficiaries with unbiased information to make managed care program selections and process voluntary disenrollment.  
**Address:** 2002 Old St. Augustine Road. Tallahassee, Florida 32308  
**Telephone No:** 1-888-367-6554 (for Miami-Dade County)  
1-866-454-3959 (for Broward & Duval Counties only)  
TDD 1-866-467-4970  
Hours Monday-Friday 8:00am – 7:00pm, Saturday 9:00am – 1:00pm

**If you should have any questions, please call the applicable Provider Relations Department as listed above.**

## **CLAIM ADDRESSES BY SUBNETWORK**

*For providers contracted or services managed by the PSN, direct claims to the following PSN Subnetwork claims address. Note: The claim is to be sent to the Subnetwork of the enrollee.*

### **Public Health Trust**

South Florida Community Care Network (PHT)  
Attn: Claims Department  
1801 NW 9<sup>th</sup> Avenue, Suite 700  
Miami, Florida 33136

### **Memorial Healthcare System**

South Florida Community Care Network (MHS)  
P.O. Box 849029  
Pembroke Pines, Florida 33084

### **North Broward Hospital District**

South Florida Community Care Network (NBHD)  
P.O. Box 21128  
Ft. Lauderdale, Florida 33335-1128

## **PROVISION OF SERVICES**

PSN covered services for enrollees shadow the benefits and limitations of the State of Florida Medicaid Program. **Refer to the Medicaid Handbooks for specific and up-to-date information.**

### **Services to enrollees under 21 years of age:**

Hearing, vision, and dental screening  
Health and developmental history  
Updating of routine immunizations  
Referrals for further diagnosis and treatment as needed  
Therapy services when medically necessary

### **Services to enrollees over 21 years of age:**

Please refer to Medicaid Handbooks, available on the AHCA fiscal agent website, <http://floridamedicaid.consultec-inc.com>.

### **Maternity Care:**

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

### **Emergency Care:**

Emergency Services are those necessary to treat a condition, illness, or injury, which requires immediate attention.

### **Hospital Inpatient Care:**

Includes all inpatient services authorized by the SFCCN: room and board, nursing care, medical supplies, diagnostic and therapeutic services. There is an annual (Medicaid fiscal year) forty-five (45) day cap on inpatient care, pursuant to Medicaid Benefits.

### **Hospital Outpatient Care:**

Includes all diagnostic and therapeutic services provided as an outpatient at a participating hospital or outpatient facility by a participating specialist. Pursuant to Medicaid Benefits there is a \$1,500.00 per (Medicaid) fiscal year cap on outpatient services for adults only.

### **Behavioral Health:**

For mental health and substance abuse services the current Medicaid benefits apply. SFCCN Reform enrollees will have behavioral health managed by University of Miami Behavioral Health (UMBH). Most SFCCN non-reform enrollees in Miami-Dade (Public Health Trust Subnetwork) will have their behavioral health care managed by UMBH as part of the Pre-Paid Mental Health (PMHP) program, but in some cases may be served instead by another plan. PMHP served enrollees will have a behavioral health enrollee ID for that program; eligibility for behavioral health services, as with all services, must be confirmed via MEVS.

### **Vision Care:**

Services allowed by Medicaid include eyeglasses, eyeglass repairs as required, prosthetic eyes, and contact lenses for eligible enrollees. Medicaid allows for two pair of glasses per enrollee per year.

**Hearing Services:**

Hearing evaluation, diagnostic testing and fitting of a hearing aid (one hearing aid every three years). Other services may include: cochlear implant services and newborn hearing screening.

**Family Planning:**

Information and referral

Education and counseling

Diagnostic testing

Contraceptives

Follow-up care to assist with spacing births

Assistance in determining problems related to infertility

Medically necessary sterilization

**Non-Emergency Transportation:**

SFCCN reform (Broward County only) enrollees will have access to Transportation Services through the SFCCN's Provider Service Network transportation vendor, LogistiCare. Reform enrollees can access these services without copay.

**Dental (for enrollees < 21 years of age):**

SFCCN enrollees under the age of 21 are eligible to receive services as designated in the Medicaid Provider Manual, which may include: partial and complete dentures, diagnostic exams, endodontics/periodontal treatment, oral surgery, orthodontic treatment, preventive services, medically appropriate radiographs (necessary to make a diagnosis), and restorations.

**Dental (for enrollees > 21 years of age):**

Adult enrollees may receive services for acute emergencies to alleviate pain and/or infection, denture, and denture-related procedures, which may include the following: complete and removable partial dentures, comprehensive oral exam, denture-related procedures, extractions, incision and drainage of an abscess, necessary radiographs to make a diagnosis, problem-focused oral exams, and surgical procedures essential to the preparation of the mouth for dentures.

## **ENROLLEE SERVICES**

The primary responsibility of the Enrollee Services Department is to facilitate and guide enrollees in accessing health care service and information about the South Florida Community Care Network (SFCCN) Provider Service Network. The main focus will be the following:

- Orient and educate new enrollees
- Determine and answer eligibility questions
- Provide information on covered and non-covered services
- Educate enrollees on SFCCN processes and services
- Provide referral/authorization status
- Provide enrollment status
- Direct enrollees to appropriate departments/resources
- Generate enrollee access to services
- Facilitate enrollee access to services
- Receive and process enrollee demographic changes
- Receive/investigate/resolve and document complaints
- Analyze/trend complaints for improvement in operations
- Log grievances received and forward to Grievance Coordinator
- Use customer feedback to improve quality of services and customer satisfaction

If for any reason an enrollee becomes dissatisfied with his/her assigned primary care provider (PCP), services, and/or location, the enrollee may request a re-assignment or PCP transfer to another SFCCN primary care provider at any time by notifying Enrollee Services. The effective date of the change will depend on the time of the month the change is received but generally it will be the first of the following month for Broward Reform enrollees if the request is received by Enrollee Services by the 22<sup>nd</sup> of the month, and in approximately 30-45 days if the request is for a non-reform/Public Health Trust Subnetwork enrollee.

## **PROVIDER SERVICES AND CONTRACTING**

The Provider Relations Department is responsible for assisting your office with the procedures required by the SFCCN. These responsibilities would include, but are not limited to: assistance with your reporting requirements, educational overviews on SFCCN compliance issues, on-site support, assistance with change of address and other practice changes, questions regarding procedures, policies, programs, reimbursement, and other general information.

Providers who wish to file a grievance may contact Provider Relations, or for an enrollee grievance, the SFCCN Grievance Coordinator.

Please contact your Provider Relations office, as listed on the enclosed SFCCN telephone contact list, to assist your office with any of the services as outlined above.

# ***PROVIDER RESPONSIBILITIES***

## **PRIMARY CARE SKILL STANDARDS**

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

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

# PRIMARY CARE PHYSICIAN CLINICAL SKILLS

The following standards define those clinical skills or services that are considered as ordinarily provided by a Primary Care Physician, and those services and conditions ordinarily requiring consultations or referrals.

## I. ALLERGY

- A. Elicit a thorough allergy history and make use of environmental controls before referring to an allergist.
- B. Treat all seasonal allergies when duration of symptoms last less than six (6) weeks per year or when symptoms occur in two (2) seasons, but the duration of symptoms last less than four (4) weeks each time. Consider referral if unresponsive to treatment.
- C. Treat chronic rhinitis aggressively with at least three (3) sequential medication programs. Consider consultation or referral if the problem is unresponsive to treatment.
- D. Treat hives aggressively while seeking the cause. Consider consultation or referral if the urticaria persists over two (2) week's duration.
- E. May administer maintenance immunotherapy injections as prescribed by an allergist consultant once allergy testing and the institution of immunotherapy injections have been completed.
- F. Diagnose and treat acute and chronic asthma. Consider consultation or referral if the treatment is unsuccessful or if hospitalization is needed. If chronic steroidal therapy is needed, consultation or referral may also be considered.

## II. CARDIOVASCULAR SYSTEM

- A. Diagnose and initiate treatment for significant heart disease and determine, in a timely manner, if consultation or referral is appropriate.
- B. Evaluate chest pain, murmurs, and palpitations.
- C. Diagnose and treat hypertension, mild congestive heart failure, and stable angina.
- D. Evaluate and treat coronary risk factors including diabetes, hyperlipidemia, hypertension, and smoking.
- E. Diagnose and evaluate syncope. Consult if the enrollee has a known history of heart disease or the cause has not been identified and the enrollee has a recurrent episode.

## III. DERMATOLOGY

- A. Treat acne with appropriate topical astringents and antibiotics for at least three (3) months using at least three (3) modalities. Consider consultation or referral if the problem is not resolved with continuing therapy or improvement ceases.
- B. Consider consultation or referral for severe cystic acne.
- C. Treat recurrent acne with a regimen that has been successful in the past, whether originated by the Primary Care Physician or the dermatologist.
- D. Diagnose common rashes and dermatoses and treat within appropriate therapeutic protocols. Refer if there has been an unsatisfactory response to treatment or for ophthalmic involvement with herpes.
- E. Diagnose and treat common hair and nail problems and dermal injuries, if appropriately trained. Refer for extensive alopecia areata or hair loss associated with infection or systemic disease.
  1. Examples of common hair problems include fungal infections, alopecia as a result of scarring or endocrine affects and ingrown hairs.
  2. Examples of common nail problems include trauma, disturbances associated with dermatoses or systemic illnesses, fungal or bacterial infections and ingrown toenail.
  3. Examples of dermal injuries include ambulatory management of minor burns, suturing lacerations, and treatment of bites and stings.
- F. Diagnose and treat actinic keratoses, if appropriately trained.
  1. Perform cryotherapy, if appropriately trained.
- G. Identify and consider consultation or referral for suspicious pigmented lesions, large or complicated lesions, lesions in immunocompromised enrollees, and lesions in high risk areas. This may include:
  1. Malignant melanoma (**always refer**)
  2. Dysplastic nevi (**biopsy or refer**)

3. Basal cell or squamous cell carcinomas (**always refer**)
  4. Other suspicious lesions. Characteristics may include:
    - a. Enlargement
    - b. Irregular margins
    - c. Color changes
    - d. Bleeding
    - e. Ulceration
    - f. Itching or pain
  5. Lesions in high risk areas include:
    - a. Head and neck
    - b. Face and ears
    - c. Genital area
    - d. Burn scars
- H. Educate the enrollee regarding the removal of certain lesions for non-diagnostic purposes. These may be considered cosmetic and, therefore, may not be covered.

Examples of lesions that may be considered cosmetic include: Liver spots, spider veins, wrinkles, skin tags, uncomplicated cyst, flat asymptomatic warts, stable lipomas, seborrheic-keratosis, non-inflamed papillomas, hereditary hypertrichosis, tattoos, and non-changing pigmented lesions without special risk.

#### IV. ENDOCRINE SYSTEM

- A. Diabetes
1. Diagnose and manage stable insulin dependent and non-insulin dependent diabetes.
    - a. Consider consultation or referral if unstable
    - b. Get consultation or referral with OB/Gyn experienced in high risk pregnancies and/or with endocrine specialist, if pregnant
    - c. Consider referral to education programs at contracted locations for newly diagnosed enrollees, new users of insulin, diabetics who are pregnant, those who travel, children and their parents
  2. Managed uncomplicated hyperglycemia that does not require intensive insulin or pump therapy. If hospitalization is needed, consider consultation.
  3. Obtain consultations for:
    - a. Coma not readily reversible by glucose
    - b. Poor control manifested by recurrent hypoglycemia, marked hyperglycemia, or persistent elevation of glycohemoglobin
    - c. Consideration of intensive insulin or pump therapy
    - d. Annual ophthalmology evaluation, especially in those enrollees over the age of 30, and those less than optimally controlled
    - e. Development and progression of complications, including peripheral neuropathy, skin lesions, impaired renal function, and ischemic symptoms and/or findings
    - f. Routine podiatry care, if PCP unable to perform
    - g. Ketoacidosis
- B. Thyroid Disorders
1. Diagnose and treat hypothyroidism and hyperthyroidism
    - a. Consider consultation for hyperthyroidism in pregnancy, involving the endocrinologist and obstetrician
    - b. Refer for radioiodine or surgical therapy if appropriate
    - c. Refer for symptomatic or moderately severe exophthalmos
    - d. Refer if not responding to treatment or if refractory to initial treatment
  2. Diagnose multi-nodular goiter. If enrollee requires thyroid suppression, consider referral to specialist.
  3. Consult for solitary thyroid nodules for consideration of biopsy and/or surgery. However, the initial work-up, i.e. thyroid scan, basic labs, etc., should be obtained by the Primary Care Physician prior to the referral.

- C. Lipid Disorders
  1. Diagnose and treat lipid disorders with diet and/or at least two (2) medications for a minimum of six (6) months. Refer if the enrollee has not responded within a six month to one year time frame. Consider referring earlier if the hyperlipidemia is quantitatively severe or if atherosclerosis is known to exist.
- D. Other
  1. Diagnose and treat osteoporosis but obtain a consultation for enrollees intolerant of traditional treatment or those complicated by multiple fractures.

## V. GASTROINTESTINAL SYSTEM

- A. Diagnose and treat common GI conditions including esophageal and reflux disease, hiatal hernia, hyper acidic and duodenal ulcer disease, infectious diarrhea, protracted vomiting, functional bowel disease, obstruction, diverticulitis and peptic ulcer disease.
  1. Refer to surgeon for suspected bowel obstruction
  2. Refer any of the above conditions if:
    - a. The diagnosis is unclear
    - b. The symptoms do not respond to therapy
    - c. The condition is refractory to initial therapy
    - d. Refer if abnormalities are found, there is associated bleeding, weight loss, or malabsorption problems
    - e. Enrollee needs colonoscopy or gastroscopy
- B. Initiate evaluation and diagnosis of liver disorders. Consultation or referral should be considered for undiagnosed hepatocellular disease or obstruction, for new or intractable ascites, or in the presence of fever.
- C. Diagnose and treat enrollees with acute pancreatitis and those with chronic relapsing pancreatitis responding to conservative treatment. Obtain consultation or referral for those enrollees with:
  1. Initial episode of acute pancreatitis
  2. Consider early surgical consultation if course of treatment is unfavorable or complicated.
  3. Enrollees with malabsorption secondary to chronic pancreatitis.
- D. Diagnose and treat symptomatic hemorrhoids. Refer if surgical intervention is required.
- E. Screen for colon cancer according to recommended schedule. May perform flexible sigmoidoscopy when indicated and if trained.
  1. Refer for colonoscopy when medically indicated.

## VI. GENERAL SURGERY

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

## VII. FEMALE REPRODUCTIVE SYSTEM

- A. Provide pelvic exams and PAP smears for female enrollees, if trained
- B. Diagnose and treat common GYN conditions including vulvovaginitis, sexually transmitted diseases, and may manage menstrual disorders such as dysmenorrhea or vaginal bleeding if appropriately trained. Consider consultation or referrals for the following:
  1. Vaginal warts
  2. GYN complaints unresponsive to medical management
  3. Complex or unusual cases
  4. Suspected or confirmed ectopic pregnancy
  5. Pelvic pain associated with abnormal vaginal bleeding
  6. Uncertain clinical diagnosis which would benefit from another opinion or laparoscopy
  7. Women for whom pregnancy would represent high risk for the mother or fetus (**should have pre-pregnancy counseling**)
  8. Vaginal bleeding in post menopausal women
  9. Moderate to severe endometriosis
  10. High risk enrollees over the age of 35 or with menometrorrhagia
- C. Diagnose pregnancy and refer for Obstetrical care

- D. Diagnose abnormal early pregnancy and refer for:
  1. Vaginal bleeding
  2. Threatened abortion
  3. Incomplete abortion
  4. Missed abortion
  5. Molar pregnancy
- E. Provide contraceptive counseling and management
- F. Diagnose pre-menstrual syndrome based on history and symptoms calendar, and manage with hormones, NSAIDS, diuretics and other symptomatic treatment as appropriate. Refer refractory cases.
- G. Order screening mammogram according to an approved schedule (**see preventive care guidelines**)
- H. Identify breast lumps and refer for surgical management
- I. Evaluate an infertile couple including history, physical exam, semen analyses, and assessment of ovulation. Refer for:
  1. Infertility of greater than two (2) years duration of unknown etiology.
  2. Anovulation
  3. Suspicion of tubal disease or endometriosis
  4. Women more than 30 years of age

### **VIII. HEMATOLOGY**

- A. Diagnose and institute appropriate testing and treatment for iron deficiency anemia, macrocytic anemia, hemolytic anemia, and sickle cell anemia. Refer for:
  1. Hypochromicrocytic anemia not due to iron deficiency
  2. Anemia not responding to treatment
  3. Inability to identify the cause
  4. Complications of sickle cell anemia
  5. Spherocytosis, immune-hemolytic anemia, thrombotic thrombocytopenic purpura, acute hemolytic crisis, and hemolysis of unknown cause
  6. Bone marrow exam
- B. Recognize the anemia of chronic disease
- C. Refer for:
  1. Suspected porphyria and hemochromatosis
  2. Unexplained polycythemia
  3. Pancytopenia
  4. Leukemia, myelodysplastic disorders, myeloproliferative disorders and lymphomas.
  5. Severe neutropenia
  6. Abnormal white blood cell morphologies
  7. Undiagnosed splenomegaly, adenopathy, or hypergammaglobulinemia.
- D. Primary Care Physician may participate with the oncologist in the management of chronic lymphocytic leukemia.
- E. Recognize bleeding disorders and diagnose most platelet and coagulation disorders. Treat stable active abnormalities. Refer for:
  1. Undiagnosed conditions
  2. Initial management
  3. Bone marrow exam
- F. Identify the need for and administer transfusion of blood products.

### **IX. NERVOUS SYSTEM**

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

- B. Diagnose and treat neurologic pain syndromes, including headaches and migraines, myofascial pain and TMJ syndrome, low back pain, lumbosacral disc disease and sciatica. Consider consultation or referral if:
  1. There is a neurologic deficit present
  2. Condition unresponsive to conservative measures
  3. No improvement after six (6) weeks of therapy
  4. Suspected intracranial disorder
- C. Manage uncomplicated stroke and/or TIA
- D. Evaluate syncope and seizures. Refer for:
  1. Initial consultation to confirm diagnosis and establish a treatment plan
  2. Confirmed seizures
  3. Recurrent seizures
  4. Condition of drug toxicity
  5. Considering discontinuing anti-convulsants
- E. Consider consultation for:
  1. Dementia
  2. Intention tremor
  3. Tic douloureux
  4. Intractable neurological symptoms
  5. Any condition in which the cause is unclear
  6. Any condition in which there is an unsatisfactory response to treatment

## **X. MUSCULOSKELETAL SYSTEM**

- A. Diagnose and treat low back pain and sciatica without neurological deficit. Consider consultation or referral if condition unresponsive to conservative measures and/or if no improvement after six (6) weeks of therapy.
- B. Diagnose and treat common musculoskeletal medical and mild traumatic problems, sprains, and acute inflammatory conditions. Consider consultation and referral for:
  1. Intractable problems
  2. Fractures
  3. Lock knee
  4. Unstable or apparent ligament tears, especially if the standing x-ray shows joint narrowing or gross destruction of articular surfaces.
  5. Severe sprains.
- C. Diagnose and refer non-displaced fractures of the clavicle, scapula, humerus, radius, ulna, hand, fingers, pelvis, patella, fibula, metatarsal, and toes. These fractures will generally be treated by splints and slings.
- D. Manage chronic pain if consultation has ruled out surgery.
  1. Soft tissue injections by the Primary Care Physician (if trained) are encouraged when clinically appropriate.
- E. Diagnose and treat common foot problems conservatively. Conservative care includes education about hygiene, proper cutting of toenails, and the treatment of corns and calluses including paring, chemical treatment (if trained) and education for home debridement by the enrollee. The enrollee should also be instructed in proper footwear, especially if the enrollee is diabetic or has peripheral vascular disease. Consider consultation or referral if:
  1. Suspect osteomyelitis, gangrene, or deep abscess
  2. Persistent intractable difficulty
  3. Post surgical problems
  4. Prosthesis or orthotic needs

## **XI. OPHTHALMOLOGY SERVICES**

- A. Perform thorough ophthalmology history including family history, symptoms and subjective visual acuity.
- B. Perform a basic eye examination including distant, near and color vision testing, gross visual field testing by confrontation, alternate cover testing, physical examination including a direct

fundoscopy without dilation, extra-ocular muscle function evaluation and red reflex testing in pediatric enrollees.

- C. Diagnose and treat uncomplicated ocular trauma including:
1. Corneal or conjunctival abrasions
  2. Contusions of the eye
  3. Superficial conjunctival or corneal foreign bodies that are not embedded, metallic, central or requiring sharp instrumentation.
- Treatment should include fluorescein staining and patching.
- D. Consider consultation or referral for:
1. All corneal burns after initial irrigation.
  2. Embedded, metallic, central or irremovable foreign bodies.
  3. Lacerations of the cornea or sclera or deep lid lacerations
  4. Hyphema
  5. Irregular pupil
  6. Proptosis
  7. Edema
  8. Suspected retinal detachment or intraocular foreign body
  9. Sudden vision loss or change
  10. Persistent severe pain without cause
  11. Absent red reflex
  12. Pediatric enrollees with disconjugate gaze or other ophthalmologic problems.
  13. Periodic examinations on diabetics over the age of 30 or those who are poorly controlled.
  14. Periodic examinations on enrollees who are taking Plaquenil.
  15. Iritis
- E. Diagnose and treat common eye conditions including viral, bacterial and allergic conjunctivitis, blepharitis, hordeolum, chalazion, small subconjunctival hemorrhage and dacryocystitis. Consultation or referral recommended when:
1. There is a high index of suspicion for Herpes
  2. Suspicion for Iritis
  3. Condition unresponsive to treatment within two (2) or three (3) days

## XII. OTOLARYNGOLOGY SERVICES

- A. Diagnose and treat tonsillitis and streptococcal infections. Consider consultation or referral if:
1. Acute tonsillitis unresponsive to four (4) weeks of antibiotic therapy.
  2. Recurrent infections with three (3) documented episodes within four (4) months or six (6) within one year.
  3. Tonsillar hemorrhage
  4. Suspected tonsillar malignancy
  5. Prolonged or recurrent peritonsillitis/peritonsillar abscess
- B. Evaluate and treat acute otitis media. Consider consultation or referral if:
1. Infections are unresponsive to two (2) different antibiotic courses of care.
  2. Dizziness, facial weakness, mastoiditis, chronic draining ear or hearing loss.
  3. Tympanocentesis
  4. Acute otitis media in a child with compromised host resistance.
  5. Persistent painful bullae of the TM unresponsive to analgesic measures.
- C. Diagnose and treat otitis externa. Consider consultation or referral if:
1. Patient fails to improve within 4 to 5 days.
  2. Enrollee is a diabetic, immunocompromised, has herpes zoster persistent otalgia (**refer immediately**).
- D. Treat acute and chronic sinusitis with up to two (2) courses of antibiotics. Refer if:
1. Infection is totally unresponsive with 72 hours. Consider earlier referral if infection is in frontal sinusitis or with periorbital cellulitis.
  2. Symptoms that persist for 20 days or more
  3. Persistent headache
  4. Recurrent infections

- E. Treat nasal obstruction and vasomotor allergic rhinitis. Consider consultation or referral if problem persists more than three (3) months.
- F. Remove ear wax
- G. Consider consultation or referral for Bell's Palsy, if diagnosis is unclear
- H. Consider consultation or referral for acute hearing loss, for persistent hearing loss not attributable to fluid or wax, for parotid masses, for hoarseness persistent for more than three (3) weeks and for hemoptysis.
- I. Diagnose and treat acute parotitis and acute salivary gland infections with antibiotics. Refer if:
  - 1. Suspicious for abscess, calculus or neoplasm
  - 2. Failure to respond to antibiotics within one week
  - 3. Recurrent infections
- J. Perform indirect laryngoscopy, if appropriately trained and office is adequately equipped.

### **XIII. PULMONARY SYSTEM**

- A. Evaluate symptoms and findings including chest pain, cough, dyspnea, hyper somnolence, increased or decreased breath sounds, rales, wheezes, cyanosis or clubbing. Obtain pulmonary function test with or without bronchodilators as indicated.
- B. Diagnose and treat common respiratory conditions including asthma, acute bronchitis, pneumonia, and COPD.
- C. Consider consultation or referral for the following:
  - 1. Persistent pleural effusions not due to heart failure
  - 2. Unresolved pneumonia or recurrent pneumonia
  - 3. Hemoptysis- persistent or of suspicious etiology
  - 4. Lung mass
  - 5. Interstitial disease
  - 6. Sarcoidosis
  - 7. Tuberculosis
  - 8. Unusual infections
  - 9. Respiratory failure
  - 10. Poor response to treatment
  - 11. Percutaneous lung biopsies, pleural biopsies or supraclavicular node biopsies
  - 12. Acute lung injury
  - 13. Suspected sleep apnea
- D. Recognize occupational lung disease
- E. Recognize opportunistic infections as possible manifestations of immunodeficiency
- F. Promote smoking cessation by repeated advice, screening pulmonary function testing, controlled nicotine administration. Encourage behavior modification or education programs, if available.

### **XIV. PSYCHIATRY**

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

- A. Perform developmental and psychosocial histories and mental status examinations when indicated by psychiatric or somatic presentations. Important somatic presentations include: fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems.
- B. Diagnose physical disorders with behavioral manifestation
- C. Make presumptive diagnoses of psychosis, major depressive disorders, other mood disorders including manic or hypo-manic episodes, dementia, substance abuse, eating disorders, anxiety disorders, attention deficit disorder and some other childhood disorders, adjustment disorders and personality disorders.
- D. Institute psychopharmacological intervention, when appropriate, and adjunctive supportive psychotherapy for the conditions listed above.
- E. Refer for the following:
  - 1. Persistent substance abuse

2. Non-compliance with or abuse of psychopharmacological, prescribed or over the counter medication
  3. Psychotic disorder
  4. Suicidal ideation, plan or intent, or depression with vegetative symptoms.
  5. Severe disassociative disorders, severe eating or pain disorders, and post-traumatic stress disorders.
  6. Suspected Attention Deficit Disorder (ADD) or Hyperactive Attention Deficit Disorder (HADD) if there is an unsatisfactory response to initial medication.
  7. Enrollee request for consultation or persistent dysfunction without resolution of the presenting symptom
- F. Provide maintenance medication management after stabilization by a psychiatrist or if long term psychotherapy continues with a non physician therapist.

## XV. RHEUMATOLOGY

- A. Diagnose and treat common rheumatologic conditions including non-specific musculoskeletal pain, bursitis, tendinitis, and osteoarthritis. Consider consultation or referral if:
  1. Unresponsive after two (2) to three (3) months of therapy
  2. Functional impairment exists
  3. Intractable pain
  4. Serious collagen vascular disease is found
- B. Diagnose and treat acute inflammatory arthritic diseases. This includes aspiration and/or injections when medically appropriate and necessary, if trained and experienced. Consider consultation or referral if:
  1. If unresponsive to treatment plan
  2. To establish a long-term management plan of care
  3. If not experienced in small joint injections
  4. If surgical treatment is being considered
- C. Diagnose and treat uncomplicated collagen diseases, cutaneous and systemic vasculitides. Consider consultation or referral depending on the extent and severity of manifestations or complications. These may include:
  1. Condition refractory to initial treatments
  2. Diagnostic uncertainty
  3. Immunosuppressive treatment is need to allow tapering of corticosteroids.
  4. Temporal arteritis (**refer immediately**)

## XVI. UROLOGY

- A. Diagnose and treat both initial and recurrent urinary tract infections. Consider consultation or referral:
  1. Identified anatomical abnormalities
  2. Persistent or recurrent infections despite chemoprophylaxis
  3. In enrollees with marked urinary frequency or irritability with negative urinalyses and cultures.
- B. Diagnose and treat sexually transmitted diseases including appropriate tests for chlamydia and gonorrhea. Consider consultation or referral for:
  1. Urethral stricture
  2. Condition unresponsive to treatment
  3. Complications
- C. Evaluate hematuria, prostatism and prostatic enlargement, and scrotal or peritesticular masses. Consider consultation or referral if:
  1. Hematuria is due to a mass or has abnormal cytology
  2. Hematuria is unexplained and persistent or recurrent
  3. Anatomic or neurologic abnormalities are identified
  4. Condition unresponsive to treatment
  5. Any condition suspicious for malignancy
  6. Enrollee has a testicular mass

7. Enrollee has a hydrocele, spermatocele or varicocele that are large enough to cause symptoms
8. Cause unknown
- D. Diagnose and treat prostatitis and epididymitis. Refer **immediately** if:
  1. Acute onset in young males that suggests testicular torsion
  2. Condition occurs post-vasectomy
  3. Recurrent infections
  4. No response to treatment
- E. Diagnose and manage small renal calculi on an outpatient basis. Consider consultation or referral if:
  1. The stone is greater than 4 mm
  2. The stone is in the proximal portion of the ureter
  3. Consideration of lithotripsy, stenting or surgical removal
  4. Fever
  5. Unresponsive to symptomatic treatment
  6. Obstruction has occurred
- F. Evaluate abnormal kidney function tests, incontinence, impotence and male factor infertility prior to a referral to a specialist. The evaluation for the specific condition may include, but not be limited to the physical exam, IVP, semen analyses, endocrine studies, etc.

## **XVII. VASCULAR SURGERY**

- A. Diagnose abdominal aortic aneurysms (A.A.A.) by examination and ultrasound. Consider consultation or referral if:
  1. Enrollee is symptomatic
  2. A.A.A. enlarging
  3. A.A.A. 5 cm or greater in diameter
- B. Diagnose thoracic aneurysms by exam and appropriate diagnostic tests. Consider consultation or referral if:
  1. Aneurysm is 5 cm in diameter or greater
  2. Aortic insufficiency or dissection is suspected
  3. Enrollee symptomatic
- C. Diagnose and treat venous disease. Refer for:
  1. Uncertain diagnosis
  2. Complications such as refractory stasis ulcers or embolization
- D. Diagnose and refer for arterial problems such as gangrene, ischemic ulcers or ischemic pain at rest.

## **ID CARDS/AUTOMATED ENROLLEE VERIFICATION SYSTEM**

Each SFCCN enrollee will receive from Medicaid a Medicaid identification card. This card is used to help identify the enrollee and check his/her eligibility in the Florida Medicaid Program. Each SFCCN enrollee will also receive a SFCCN identification card, and a behavioral health ID card if they are a PHT enrollee participating in the Pre-Paid Mental Health Program (PMHP) [see attached example], which has valuable information on both sides. **Possession of any of these identification cards does not guarantee current Medicaid or PSN eligibility.** The provider **must** verify eligibility by using Medicaid's Eligibility Verification System (MEVS), with various vendors available. Enrollees have been asked to carry these cards at all times. The SFCCN card provides additional information to providers, including:

- The name of the enrollee's PCP or clinic and phone number, the PSN Subnetwork in which the enrollee belongs [PHT for Public Health Trust in green; MHS for Memorial Healthcare System in burgundy; and NBHD for North Broward Hospital District in blue].
- Phone numbers for hospital admission and for authorization of services

## **VERIFICATION OF ENROLLMENT**

All providers are strongly encouraged to verify eligibility prior to services being rendered. Eligibility needs to be verified even if a provider has a referral and authorization number. The gold card furnished to enrollees by Medicaid can be used (swiped) for MEVS checking of eligibility.

On MEVS transactions, the SFCCN managed care indicator should show that the enrollee is enrolled in a PSN with a letter "S" where PROVIDER TYPE is indicated. **Note:** C=CMS, H=HMO, M=MediPass, S=PSN. MEVS will denote which plan/Subnetwork the enrollee belongs. If the enrollee is in a Broward Reform plan, MEVS will indicate this by an "R" prior to the plan name. For the Memorial Healthcare System, MEVS should indicate "R-SO FL COMM CARE/MHS". For the North Broward Hospital System, MEVS should indicate "R-SO FL COMM CARE/NBHD". For PHT (and non-reform Broward enrollees in NBHD or MHS), MEVS is not PSN specific; it shows that the individual is enrolled in a PSN but it does not indicate which PSN. If you are the PCP or clinic of record in the AHCA information system, your name and the practice phone number should be present as PLAN/PROVIDER and MANAGED CARE PHONE NUMBER. Please note that not all MEVS vendors provide the same information in the same manner. Please contact Enrollee Services for assistance with specific enrollee issues.

## **PCP RESPONSIBILITIES, PROCEDURES & NEW ENROLLEE PROCESSING**

To encourage enrollees to visit their PCP, the SFCCN Enrollee Services Department will contact each new enrollee by mail through an introductory letter that includes the name, address, and phone number of the enrollee's PCP. The mailing includes information regarding SFCCN benefits and it requests enrollees to make an appointment with his/her PCP for an initial health assessment. The mailing also includes a Health Risk Assessment and Medical Release Form. A postage paid envelope is provided to enrollees for return to the SFCCN. When the Health Risk Assessment is received by the SFCCN Subnetwork Case Management Department, a nurse will review it to identify any need for the enrollee to be followed by case management or possibly benefit from a SFCCN Disease Management Program. The original form with valuable information will then be forward to you for review, action, and for final **placement in the enrollee's medical record.** If you have not already initiated a medical record for the enrollee, this is the opportunity. Be sure to document any attempts to reach the enrollee.

In addition to the contact by the SFCCN, PCP's should welcome their new enrollees and request they seek an initial health screening. At the first visit, enrollees should be requested to authorize the release of their medical records to you, their new PCP. Once received by you, you can identify if the enrollees have received past screenings according to the AHCA approved schedules, and it facilitates continuity of medical care by having knowledge of the enrollee's past medical history and treatment.

Primary care providers are strongly encouraged to participate in the Florida SHOTS program, a free statewide, online immunization registry sponsored by the Florida Department of Health. This program provides an easy tracking tool for providers; it prospectively forecasts upcoming immunizations needs, and is able to produce the 680 form required by law for schools and child care centers, eliminating additional work by providers. Additional information can be found on the Florida SHOTS website, [www.flshots.com](http://www.flshots.com), by phone at (877) 888-SHOT (7468), or by email at [flshots@doh.state.fl.us](mailto:flshots@doh.state.fl.us).

## **PCP RESPONSIBILITIES WITH NON-COMPLIANT ENROLLEES**

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

**“Failure to show”** is defined as an enrollee who has missed three (3) consecutive appointments within a six-month time period with the same health care provider or facility and does not notify the health care provider that he/she is unable to keep the scheduled appointment.

**“Failure to follow plan of care”** is when an enrollee chooses not to comply with the prescribed plan of care.

**“Provider Requests to Remove an Enrollee From PCP Panel”** is when providers need to make a reasonable effort to establish and maintain a satisfactory relationship with enrollees. When such a relationship can not be established or a breakdown occurs, the PCP has the right to request termination of the relationship by withdrawing as the enrollee's PCP. Such a request needs to be communicated to your PSN Provider Relations representative. Each case will be evaluated individually to ascertain if a change in PCP is an option or there is a need for the PSN to initiate an involuntary termination request from the PSN through AHCA. This latter action by the SFCCN requires substantial reason and record keeping by the provider to justify the involuntary disenrollment. After ample notification by the provider, if the enrollee fails to correct the situation the PCP should notify, by certified mail, the enrollee and PSN Provider Relations Department his/her request to terminate his/her relationship with the enrollee as the PCP. The PCP is expected to continue providing care until the effective date of the change which generally is the first day of the next month otherwise, it is the month following if the request is late in the month. The PCP should instruct the enrollee to seek assistance from the SFCCN Enrollee Services Department at 1-866-899-4828.

# **BILLING AND PAYMENT FOR SERVICES**

## *PRIMARY CARE PROVIDERS*

Payment to Primary Care Providers shall be a case management fee of \$3.00 per enrollee per month. Case management fees are paid by the Medicaid fiscal agent by the second week of each month to providers in the PHT Subnetwork. MHS and NBHD will pay the case management fee (and any additional funds) directly to their contracted Reform providers. There will also be additional funds paid by the SFCCN through incentives for meeting set Performance Indicators, in accordance with the terms of the "Provider Services Agreement". Primary Care Providers will receive compensation at 100% of the current Florida Medicaid fee schedule minus any allowable co-payments collected by and directly paid to providers, for Medicaid covered services.

## *SPECIALISTS AND ANCILLARY PROVIDERS*

Specialist and ancillary providers will receive compensation at 100% of the current Medicaid fee schedule minus any allowable co-payments collected by and directly paid to providers, for Medicaid covered services.

## *BILLING PROHIBITIONS*

Provider shall accept payment made by the Agency's fiscal agent, in accordance with the terms and conditions of the "Provider Services Agreement", as payment in full and accept no payment from SFCCN enrollees, the enrollee's relatives or any other person or persons in charge as the enrollee's designated representative, in excess of the reimbursement rate made by the Agency. This does not include applicable Medicaid co-payments. In no event, including, but not limited to, non-payment by SFCCN or the Agency, insolvency of SFCCN or termination of your Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Enrollee or the Agency or persons, other than the SFCCN, acting on the Enrollee's behalf, for contracted services pursuant to your Provider Services Agreement.

## *COPAYMENT COLLECTIONS*

Enrollees have a co-payment established by Medicaid of \$1.00, \$2.00 or \$3.00 depending on the services being rendered. Providers are responsible for the co-payment collection. The co-payment dollars are deducted from the claim dollars paid by the Medicaid fiscal agent when an encounter or service has a co-payment as delineated by Medicaid. This deduction occurs whether or not the provider collects it from the enrollee. These co-payments are waived for certain situations such as enrollees under age 21, and pregnant enrollees. Broward Reform enrollees who are eligible to receive services from the SFCCN transportation provider LogistiCare, will not have a co-payment for those services.

## *MEDICAID CLAIMS/BILLING TRAINING CLASS*

Medicaid offers providers and their office staff Medicaid billing training classes. For more information please contact the Area 10 (Broward), Medicaid Office at (954) 202-2000 or Area 11 (Dade) Medicaid Office at (305) 499-2000.

## *THIRD PARTY LIABILITY (TPL) CASES*

It is the Provider's responsibility to alert the Subnetwork if an enrollee has coverage in addition to SFCCN enrollment. The SFCCN will then forward this information to Medicaid's Third Party Liability Unit (TPL Unit) for research.

## *MEDICARE DUAL ELIGIBILITY*

SFCCN-PSN Broward Reform enrollees may have both Medicaid and Medicare. Billing and coordination of care should follow the normal dual eligibility requirements and claims rules.

# CLAIMS OVERVIEW

## BILLING ADDRESS

SFCCN Providers (and providers rendering SFCCN managed services) are responsible for submitting clean, complete, and accurate claims to the South Florida Community Care Network, in hard copy form or any other approved format to the following address:

<p style="text-align: center;"><b>SOUTH FLORIDA COMMUNITY CARE NETWORK</b> <b>TCA</b> <b>CLAIMS DEPT.</b> <b>P.O. BOX 21128</b> <b>Ft. Lauderdale, FL 33335-1128</b></p>
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## CLAIMS SUBMISSION

Providers shall submit claims for SFCCN Managed Services promptly and in accordance with the Florida Medicaid program to the SFCCN Subnetwork of the enrollee. Providers are required to conform to all the Medicaid billing requirements. All claims should be received by the SFCCN within sixty (60) days from the date of service. Claims submitted after a twelve (12) month period from the date of service will automatically be denied by the SFCCN and Medicaid fiscal agent. Claims should be submitted on the red CMS-1500 form or in any other format approved by Medicaid.

Please ensure the claim contains the following information:

- Enrollee 10 digit Medicaid I.D. number (field 1a)
- Enrollee's name (field 2)
- Name of referring physician or other source (field 17)
- Referring physician's ID number (field 17a)
- Claim type (field 19)
- Diagnosis codes [ICD-9] (field 21)
- Subnetwork authorization number (if applicable)\* [on UB-92 place in box 63, on CMS-1500 form place in box 23]. See sample forms on next 2 pages.
- Date of service (field 24a)
- Place of service (field 24b)
- Services rendered [CPT-4, DRG, Revenue code, etc.] (field 24d)
- Diagnosis code (field 24E; enter diagnosis code reference number in block 21)
- Usual & Customary Charge (field 24f)
- Units of service (field 24g)
- Two-purpose box (field 24k; 3<sup>rd</sup> party insurance paid & treating provider # if provider in #33 is group)
- Total charges (field 28)
- Payment from another insurance [never enter Medicaid co-payment or Medicare payment] (field 29)
- Sign and date the claim form ['wet signature' of provider] (field 31)
- Provider's full name, Medicaid ID number, billing address, telephone number (field 33)

For medical services requiring authorization, see listing located under Utilization Management section of this manual.

Please refer to the Medicaid Physician Coverage and Limitations Handbook for claims requiring attachments. These claims are to be submitted to the applicable Subnetwork claims address listed on the SFCCN contact sheets at the beginning of this manual.

## **CLAIM INQUIRIES**

### **CLAIMS PAYMENT**

The Medicaid fiscal agent will pay claims directly to the provider. If you have inquires regarding late claim payment or have other claim inquiries, please contact the SFCCN Subnetwork (of the enrollee) at:

**SOUTH FLORIDA COMMUNITY CARE NETWORK  
TCA  
CLAIMS DEPT.  
P.O. BOX 21128  
Ft. Lauderdale, FL 33335-1128**

### **PRIMARY CARE PROVIDER CASE MANAGEMENT FEE INQUIRIES**

All case management fees for Broward Reform providers are paid by the SFCCN Subnetwork. Case management fess for Miami-Dade providers are paid by the Medicaid fiscal agent (MFA), thus for Miami-Dade providers, any inquiries should be directed to the MFA.

### **PROVIDER APPEALS**

If a denial letter is received from the South Florida Community Care Network, please direct appeals to:

**MEMORIAL INTEGRATED HEALTHCARE  
TCA  
P.O. BOX 21128  
Ft. Lauderdale, FL 33335-1128**

If you receive a denial from the Medicaid fiscal agent, direct inquiries to Medicaid's fiscal agent ACS.

# **PROVIDER RESPONSIBILITIES REGARDING ADDRESS AND PRACTICE CHANGES**

## **OFFICE CHANGES**

It is imperative that you notify your Provider Relations Representative of changes in your practice, prior to the effective date of the change. This information is essential for Provider Directory revisions and ensures continuity of care for the enrollee. This information should include, but is not limited to:

- Address
- Phone Number
- Tax ID Number
- Change of Name/Practice Name
- Date Change Effective
- Provider Leaving/Joining Group Practice
- Addition/Deletion of Hospital Privileges

The Medicaid fiscal agent also needs to be promptly notified of changes.

## **ADDING NEW ASSOCIATES**

If a new provider is being added to your practice, please contact your Provider Relations representative to obtain a provider application. To be a participant in the SFCCN, the provider must be a Medicaid provider, have an active Florida Medicaid Provider number, and be a provider in good standing with the State of Florida Medicaid Program. The new provider must complete the application process and obtain credentialing approval prior to active participation in South Florida Community Care Network.

## **PRIMARY CARE PROVIDER REQUESTING TO CLOSE PANEL**

Primary Care Providers need to submit to South Florida Community Care Network in writing any requests to close their panel to accept new enrollees. This letter needs to include the reason for closing their panel and an estimated time frame for non-acceptance of enrollees.

## **PROVIDERS REQUESTING TO TERMINATE FROM THE SFCCN**

A SFCCN provider wishing to terminate his/her agreement with the Subnetwork where he/she has a contract may do so by providing sixty (60) days advance written notice. Unless otherwise agreed to by both parties, termination shall be effective upon the first day of the month following expiration of the next sixty (60) day advance written notice.

## **PHARMACY SERVICES**

The SFCCN needs your active participation in the management of Prescribed Drug Services to SFCCN enrollees. Utilization of prescription drugs is a major component in the cost structure of the network. Lack of control in this area will only serve to weaken our ability to effectively provide the superior care desired by all.

Covered drugs, injectables, food supplements and other prescribed drug services are described in the Medicaid Prescribed Drug Services Coverage and Limitations Handbook. All Medicaid Program prior authorization requirements for pharmaceuticals are applicable to SFCCN enrollees. Only pharmaceuticals covered by Medicaid and those that are FDA approved may be prescribed. Provider participation in the Vaccine for Children Program is mandatory for all primary care providers (primary care provider groups). If you are not currently participating in this program, please contact your Provider Services Representative for assistance.

Your prudent use of network resources is of great benefit and value. We encourage you to utilize generics whenever possible. We request that you proactively educate your patients as you see them and that you participate with us in educational initiatives. Your cooperation will be greatly appreciated.

## **PROVIDER COMPLIANCE**

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

## **CULTURAL COMPETENCY**

The SFCCN requires all providers to be trained on the SFCCN Subnetwork Cultural Competency Plan. The plan includes a description how providers can effectively provider services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individual enrollees and protects and preserves the dignity of each. A full copy of the cultural competency plan for the contracted provider's Subnetwork health system will be provided within 30 days of the execution of a contract with the SFCCN. Upon revision, a new Cultural Competency Plan will be distributed to all current primary care providers and specialists.

***ENROLLEE  
INFORMATION***

## **PRIMARY CARE PROVIDER ASSIGNMENT**

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

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

## **PCP TRANSFER REQUESTS**

The South Florida Community Care Network strives to maintain a positive relationship between the enrollee and his/her primary care provider. Enrollees may request a PCP change (transfer) by calling the SFCCN Enrollee Services Department (1-866-899-4828). Transfer requests may be initiated by the enrollee or the enrollee's legal guardian. If the request is received on or before the 22<sup>nd</sup> of the month for Broward Reform enrollees, the effective date of the change will be the first (1<sup>st</sup>) of the next month. If the request is received after the 22<sup>nd</sup> of the month, the effective date will be the first (1<sup>st</sup>) day of the month after next. PCP changes for PHT enrollees in Miami-Dade will occur approximately 45 days after the request is made. The enrollee will receive a new SFCCN ID Card from Enrollee Services indicating the new PCP name. The enrollee's current PCP is expected to continue providing care until the effective date of the change.

## **ENHANCED BENEFITS**

Broward Medicaid Reform enrollees are able to receive credit up to \$125 per year for healthy behaviors. This includes childhood wellness visits, dental exams, vision exams, mammograms, PAP smears, colorectal screening, adult vision exams, and adult dental exams. A full list is available from the Enhanced Benefits website listed below. The earned credit is good towards the purchase of health related supplies from participating pharmacies. This may include infant formula, over the counter drugs, and other health related items. This list is also available on the Enhanced Benefits website, which also lists the 'value' of each healthy behavior and the maximum that can be earned from the behavior each year. Enrollees must fill out an enhanced benefit form, called an "Enhanced Benefit Universal Form" in order to gain credit for some behaviors. Other behaviors are captured through claims. Additional information is available: online at the AHCA website for Enhanced Benefits at [http://ahca.myflorida.com /Medicaid/medicaid\\_reform/enhab\\_ben/enhanced\\_benefits.shtml](http://ahca.myflorida.com /Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml); by calling the AHCA Enhanced Benefits Call Center at 1-866-421-8474, or by sending an email to [enhancedbenefit@ahca.myflorida.com](mailto:enhancedbenefit@ahca.myflorida.com).

## **ENROLLEE RIGHTS AND RESPONSIBILITIES**

The South Florida Community Care Network strives to foster enrollee satisfaction, respect, and availability of information through open communications. We, therefore, have written the following Enrollee Rights and Responsibilities.

### **RIGHTS:**

- Each enrollee has the right to be treated with respect, courtesy, and dignity.
- Each enrollee has the right to choose their primary care provider.
- Each enrollee has the right to have his/her privacy protected.
- Each enrollee has the right to be assisted in a prompt, courteous and responsible manner.
- Each enrollee has the right to be provided with information about his or her diagnosis, treatment, and prognosis in terms that are understandable to him or her.
- Each enrollee has the right to have his/her medical record and all other information kept confidential unless permission to release such information has been given by the enrollee or is requested by law.
- Each enrollee has the right to have his or her medical record and all other information kept confidential unless permission to release such information has been given by the enrollee or the release is required by law.
- Each enrollee has the right to participate in decisions regarding his or her care.
- Each enrollee has the right to express grievances regarding the program or any violation of his/her rights.
- Each enrollee has the right to a second opinion from a qualified health care professional, within or outside of the network, at no cost to them.
- Each enrollee has the right to request any of the following information:
  - The authorization and referral process for health services;
  - How the SFCCN decides whether health care services are medically necessary;
  - The quality assurance program;
  - The prescription drug benefits program;
  - Policies about keeping an enrollee medical record and medical information confidential;
  - How the SFCCN/PSN chooses its doctors.
  - How the PSN is structured and operated including any provider incentive plans.

### **RESPONSIBILITIES:**

- Each enrollee has the responsibility to try to be considerate and respectful of all treatment staff and to cooperate with the treatment staff. This includes following instructions from those rendering health care services and enrollees providing the staff with the information they need. If the enrollee has questions or disagrees with the treatment plan, he or she has the opportunity to discuss it with his or her doctor and the other treatment staff.
- Each enrollee has the responsibility to carry his/her ID cards at all times and call his/her doctor or other health care providers when an appointment can not be kept.
- Each enrollee has the responsibility to call his/her doctor and the Enrollee Services Department if he/she has a change of address or telephone number.
- Each enrollee has the responsibility for following the plan of treatment outlined by his or her physician or, if not possible, to request a new plan of treatment or alternately request assignment to another doctor.

# **ENROLLEE GRIEVANCES AND APPEALS**

## **Grievance Department**

Office Hours: 8:00 am – 7:00 pm

Phone: 1-866-899-4828

South Florida Community Care Network

1525 N.W. 167 Street, Suite 103

Miami, FL 33169

If an enrollee is not satisfied with a service or provider and would like to file a grievance, he or she may do so by calling the SFCCN Enrollee Services Department at 1-866-899-4828 or may submit a grievance by using a SFCCN grievance form or a descriptive letter. A copy of the form is attached and it can be duplicated for enrollee use. The following outlines the procedure.

## **ENROLLEE GRIEVANCES**

If an enrollee is dissatisfied with services provided by the PSN, you or the enrollee can call the SFCCN Enrollee Services Department at 1-877-838-7526 to request assistance. If the enrollee's problem is not resolved by Enrollee Services, you can file a grievance within one (1) year of what made the enrollee dissatisfied, with the written permission of an enrollee.

You can assist the enrollee to file the grievance by fax, email, by calling us toll-free at 1-866-899-4828, or by sending a letter to us at:

South Florida Community Care Network  
1525 NW 167 Street, Suite 103  
Miami, FL 33169  
Attention: Grievance Coordinator

We will send the enrollee a letter approximately 5 days after we receive the grievance to let him/her know their rights and our procedures. If we have resolved the grievance within that time, we will also tell the enrollee the result of our investigation.

A copy of our grievance form is available for duplication by your office, as included in this provider manual. Should you need an additional copy, please contact your Provider Services Representative.

We will investigate the grievance, and provide the enrollee with a written explanation of our findings within 60 days, unless services were received outside of the service area (Dade/Broward), in which case notice will be provided within 90 days.

If the enrollee is not satisfied with the resolution of the grievance, the enrollee can request another review with the Grievance Committee. This Committee will meet to review the grievance at a place convenient to the enrollee, and with the enrollee's permission, you can assist in representation of the enrollee. If the grievance is related to an urgent condition, the review of the original grievance and/or a request for another review of the resolved grievance will be within 72 hours.

The enrollee can, at any time during the grievance process, ask for a Medicaid fair hearing, which can be requested by writing to the DCF Office of Public Assistance Appeals Hearings, 1317 Winewood Boulevard, Building 5, Room 203, Tallahassee, Florida 32399-0700. At this hearing, you can also represent the enrollee with the enrollee's written permission.

## **ENROLLEE APPEALS**

If the enrollee receives a notice of action, he/she has the right to appeal. An action is:

1. The denial or limited authorization of a requested service, including type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, or payment for a service;
4. The failure to provide services in a timely manner, as defined by the state;
5. The failure of the PSN to act within the timeframes provided in Section 438.408.

You can assist the enrollee to appeal on the phone, but it must then be sent to us in writing. You must have the enrollee's permission in writing to appeal on their behalf. The appeal letter must be sent within 30 days to:

South Florida Community Care Network  
1608 S.E. 3<sup>rd</sup> Avenue, Suite 507  
Ft. Lauderdale, FL 33316  
Attention: Grievance Coordinator

We will review the appeal and tell the enrollee what we found no later than 45 days after we receive the request. If the appeal was in writing only, the 45 days starts from the day we receive the written appeal. If the appeal was by phone and then by letter, the 45 days starts the day of the verbal appeal. We will notify the enrollee in writing if we need an additional 14 days to process their appeal.

You can ask on the enrollee's behalf that the service being appealed be continued while we are making a decision if a letter is sent to us within 10 days of our letter to the enrollee of our action (15 days if the letter is sent by mail). But, the appeal has to be for the stopping or reducing of something we had already approved. And, it needs to be in its approved time period and ordered by a doctor we have approved. However, if the enrollee does not win the appeal, they may have to pay for their care.

If the PSN continues or restarts the enrollee's benefits while waiting for a Medicaid Fair hearing, services can continue until:

1. You (on the enrollee's behalf) or the enrollee asks us to stop reviewing the appeal.
2. Ten (10) days pass from our action, and you (on the enrollee's behalf) or the enrollee have not asked for a Medicaid fair hearing and to receive services until a fair hearing decision is made (five (5) additional days if we send the notice in the mail).
3. The Medicaid fair hearing decision was ruled in our favor.
4. The authorization expires or the enrollee received all the services he/she is allowed.

## **EXPEDITED APPEALS**

Expedited appeals are appeals that need a faster review because of the enrollee's health. You or the enrollee can ask for a faster review (urgent appeal) by phone or by letter. We will notify you and the enrollee of our decision within 72 hours. We will try to call you and the enrollee about the results right away. We will also mail the enrollee a letter within 2 working days.

The letter of appeal should be sent to the SFCCN at:

South Florida Community Care Network  
1608 S.E. Third Avenue, Suite 507  
Ft. Lauderdale, FL 33316  
Attention: Grievance Coordinator  
1-866-899-4828

## **BENEFICIARY ASSISTANCE PROGRAM**

Enrollees have the right to access the State Beneficiary Assistance Program (BAP) as an additional level of appeal. An enrollee can access the BAP after exhausting the SFCCN's Grievance and Appeals process, except when the enrollee has requested or is participating in a Medicaid fair hearing for the matter. The BAP must receive the request for review from the enrollee (or their designee with appropriate documentation for representation) within one (1) year of the receipt of the final decision letter from the SFCCN. A review by the BAP can be requested in writing to or by phone at:

Agency for Healthcare Administration  
Beneficiary Assistance Program  
Building 1, MS #26  
2727 Mahan Drive, Tallahassee, FL 32308  
(850) 921-5458  
(888) 419-3456 [toll-free]



**--FOR SFCCN OFFICE USE ONLY--**

CASE NO.:

SUMMARY OF FINDINGS:

IDENTIFIED OPPORTUNITIES FOR QUALITY IMPROVEMENT:

DATE RECEIVED BY GRIEVANCE COMMITTEE: \_\_\_\_\_

GRIEVANCE RESOLVED TO SATISFACTION OF ENROLLEE: YES \_\_\_ NO \_\_\_

**SUBMIT TO: SOUTH FLORIDA COMMUNITY CARE NETWORK, 2900 Corporate Way, Miramar, FL 33025**

**FORM ADM-2**

# ***UTILIZATION MANAGEMENT***

## **REFERRAL PROCEDURES**

Turn around times for authorization of requested services are as follows:

- a) emergency requests will not exceed four (4) hours
- b) urgent requests will not exceed one (1) business day
- c) routine requests will not exceed three (3) business days
- d) requests under pended status will not exceed five (5) business days

InterQual criteria and Medicaid Coverage and Limitations Handbooks will be used to evaluate requests for medical appropriateness/necessity.

Requests for services that do not meet criteria due to lack of information will be pended and returned to the requesting physician/provider's office for additional information. If, after receiving the additional information, InterQual criteria is still not met, the request will be forwarded to the Subnetwork's Medical Director for review and determination.

Authorization will be required for all items listed on the SERVICES REQUIRING PRIOR AUTHORIZATION listing. Each Subnetwork utilizes Medical Service Authorization/ Request forms. A sample copy of each is attached.

Any services on the authorization list, which are rendered/performed without an authorization number will be denied for lack of authorization. Authorization numbers will be assigned by each Subnetwork of the SFCCN.

**PLEASE REFER TO THE ATTACHED LIST OF SERVICES THAT REQUIRE PRIOR AUTHORIZATION. AUTHORIZATIONS ARE VALID UP TO 60 DAYS FROM THE ISSUE DATE.**

## SERVICES REQUIRING PSN AUTHORIZATION

All Out of [Subnetwork] and SFCCN Services (requires review and authorization by the Subnetwork Medical Director of his/her designee)

Chemotherapy

Consults – Outpatient:

1. All out of Subnetwork
2. All out of SFCCN network referrals
3. Specialist to specialist referrals (MHS & NBHD only)
4. All specialist referrals (PHT only)

Dental Services specific to Orthodontics, Dentures, and Appliances (MHS & NBHD Subnetworks only)

Dialysis (peritoneal & hemodialysis)

Elective Surgery (Inpatient, Outpatient, Ambulatory Surgery)

Emergency Visits (authorization is for payment only, not service approval)

All Invasive Diagnostic procedures to incl. but not be limited to endoscopies, cardiac catheterizations, electrophysiologic studies (EPS), angiograms, cystograms, and amniocentesis.

Growth Hormone Treatment

Home Health Care /DME/Oxygen & Related Equipment and Services

Hyperbaric Oxygen Therapy

Inpatient Admissions (Emergency and Non-Emergency)

Mental Health Inpatient Admissions

MRI

Nerve Conduction Studies /EMG

Observational Stays

Obstetrical Care (Block Authorization)

Oral Surgery

Orthotics /Prosthetics

PET Scans

Pharmacologic/Exercise/Echo Stress Tests (Thallium, Cardiolyte, etc.)

Plastic Surgery

Radiation Therapy

Sleep Apnea Studies and Related Care

Therapy Services – Speech/Occupational/ Physical Therapies

Transplants and Related Care

Any service authorizations / pending cases prescribed or authorized before the enrollee's effective date with the PSN.

**\* see Subnetwork specific addendums**

## **PRIOR AUTHORIZATION FOR NEW ENROLLEES TO THE SFCCN**

Enrollees become effective in the SFCCN either via a voluntary process (the individual elects the SFCCN) or by an assigned process by AHCA when an individual does not choose a Medicaid managed care program.

For both voluntary and assigned enrollees, written documentation of prior authorization of ongoing services will be honored within the designated time frame of enrollment in the SFCCN or until the SFCCN's PCP reviews the enrollee's treatment plan, whichever comes first. Services need to have been pre-arranged prior to enrollment in the PSN. These services include:

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

The timeframes are defined as:

**For voluntary enrollment** – Prior authorized services will be honored for up to thirty (30) days after the effective date of enrollment in the SFCCN or until the SFCCN's PCP reviews the enrollee's treatment plan, whichever comes first.

**For assigned enrollment** – Prior authorized services will be honored for up to one (1) month after the effective date of enrollment in the SFCCN's or until the PCP reviews the enrollee's treatment plan, whichever comes first.

The SFCCN shall not delay authorization if written documentation is not available in a timely manner.

# UTILIZATION PROCEDURES

## EMERGENCY SERVICES

Notification of emergency room visits provides a mechanism for the Subnetwork to capture data, identify potential access to care issues and notify the Primary Care Provider (PCP) of the encounter in an effort to expedite follow-up care. The enrollee in the emergency room who becomes admitted will require an authorization number for the inpatient admission to be issued by each Subnetwork at the time of notification and determination of medical necessity.

### **Scope of Service:**

Emergency services will be provided to all enrollees in accordance with State and Federal laws. Each Subnetwork of the South Florida Community Care Network (SFCCN) will monitor emergency room utilization.

Emergency services and care are defined as: medical screening, examination and evaluation by a physician, or to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists; if such a condition is determined to exist, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

Once the Subnetwork's Utilization Management Department is notified of the emergency room visit, the PCP will be notified as well via fax or telephone by the Subnetwork in order to initiate appropriate follow up care.

### **Enrollees shall not be sent to the emergency room for the following conditions:**

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

## **OUTPATIENT HOSPITAL SERVICES**

Referrals for outpatient hospital services will be processed by the Utilization Management Department of each Subnetwork. Please refer to the Utilization Management section of this manual entitled “Referral/Authorization Process.”

Outpatient hospital services are defined as preventative, diagnostic, therapeutic or palliative services provided at a licensed hospital or an outpatient basis under the direction of a physician or dentist.

Outpatient hospital services include emergency room, dressings, splints, oxygen and physician ordered supplies necessary for the clinical treatment of a specific diagnosis or treatment as specified in Medicaid Hospital Coverage and Limitations Handbook.

Medicaid reimbursement for outpatient hospital services is limited to \$1500.00 per Medicaid fiscal year for recipients 21 years of age and older. With the Medifax eligibility system, the dollar amounts that are seen indicate claims paid as of the inquiry date.

There are no dollar limitations for recipients under the age of 21.

The Medicaid reimbursement referred to above for outpatient hospital services excludes surgery, obstetrical procedures, dialysis services, the fitting of burn garments and the garments themselves.

SFCCN providers may not bill for office visits and related procedures as “outpatient” or “facility charges”.

Primary care services provided in hospital-owned outpatient clinics and satellite facilities cannot be billed on the UB-92 claim form.

Physician services must be billed using the CMS-1500 claim form.

## HOME HEALTH SERVICES

Home Health Services, whether at the time of discharge from a hospital or from the community, **MUST BE ORDERED BY THE ATTENDING PHYSICIAN** or **PRIMARY CARE PROVIDER (PCP)**. The request should be faxed to the Utilization Department either by the provider's office or the designated accepted entity as per each Subnetwork.

Physician orders for home health services shall be accepted when provided in writing and minimally describe:

- The enrollee's acute or chronic medical condition that causes the enrollee to need home health care;
- Documentation supporting the medical necessity for the service(s) to be provided at home (enrollees must be deemed homebound);
- The specific home health service(s) needed, including the frequency and duration;
- The minimum skill level of staff who can provide the service(s)

Follow-up with the enrollee during the course of treatment under Home Health will be conducted by Case Management.

The Subnetwork's Case Management Department may also notify the PCP/ordering provider of the enrollee's progress with treatment. This action does not replace the PCP-Home Health Agency communication, but enhances collaboration between all parties.

The attending physician/PCP must review the plan of care at least every 60 days. Each plan of care must incorporate or include as a separate document, physician orders for home health services. Photocopies of previous plans of care are not acceptable. Orders for recertification of services are the responsibility of the home health agency to initiate. Physician orders to initiate or continue home health services must be signed by the attending/ordering physician before submitting a request for precertification of service authorization. If the home health service does not require precertification or service authorization, physician orders to initiate or continue home health services must be signed by the attending/ordering physician before a claim for payment is submitted. Verbal orders must be in writing and countersigned by the attending/ordering physician or validated by physician faxed orders before requesting precertification or service authorization or submitting a claim for payment. Medicaid will reimburse home health services ordered by an ARNP or Physician Assistant only if the order is countersigned by the attending/ordering physician. Recertification is minimally required every 180 days to conform with the Medicaid Handbook.

If the PCP/provider does not certify a continued need, the enrollee and the Home Health Agency will be notified that the PSN will not be authorizing continued services and will not be responsible for payment if the service is rendered past the date of the notification or disenrollment of the enrollee.

**PLEASE NOTE THAT EACH SUBNETWORK HAS CONTRACTED HOME HEALTH CARE AGENCIES. ENROLLEES MAY NOT DIRECTLY SEEK SERVICES OR CALL THE COMPANIES. YOU NEED TO SEEK AUTHORIZATION AND COORDINATE THE CARE WITH THE ENROLLEE.**

**PLEASE REFER TO YOUR SUBNETWORK'S LIST OF PROVIDERS FOR HOME HEALTH.**

## **DURABLE MEDICAL EQUIPMENT**

Durable Medical Equipment (DME) must be ordered by the provider and the referral request must be submitted to the Utilization Department of the enrollee's Subnetwork.

A plan of care should be submitted along with the Pre-authorization/Referral form specific for that Subnetwork.

The enrollee may be contacted by the Subnetwork's Case Management Department during the course of treatment.

The Subnetwork's Case Management Department may also contact the provider to discuss the enrollee's progress with requested plan of care and may recommend alternatives, if indicated.

Note that a physician's order for DME will expire every year for rental items and every six (6) months for supplies. These will have to be re-certified. This re-certification will either be initiated by the Case Management Department of the Subnetwork or by the ancillary provider.

If the PCP/Provider does not certify a continued need, the enrollee and the DME provider will be notified that the SFCCN will not be authorizing continued services and will not be responsible for payment if the service is rendered past the date of the notification or disenrollment of the enrollee.

**PLEASE NOTE THAT EACH SUBNETWORK HAS SPECIFIC CONTRACTED VENDORS FOR DME. PLEASE REFER TO THE LIST PROVIDED BY YOUR SUBNETWORK FOR DME.**

## **LABORATORY SERVICES**

Laboratory services will be contracted by each Subnetwork.

For the individual lab providers for each Subnetwork, please refer to each Subnetwork's Provider Network insert in this manual. Providers, however, may utilize any Medicaid lab for SFCCN enrollees. Outpatient lab services should be used when possible to preserve the maximum benefit for adults

## **BEHAVIORAL HEALTH SERVICES**

Behavioral Health Services, both inpatient and outpatient, are managed by University of Miami Behavioral Health (UMBH) under contract with the SFCCN and require preauthorization from UMBH, except for emergencies or use of Community Mental Health Centers (CMHCs). Behavioral Health Services must be provided by a provider contracted with UMBH as a member of the UMBH Network. To obtain assistance in making a referral call UMBH at 1-800-294-8642. UMBH will monitor use of emergency rooms and re-admission rates for Behavioral Health Services and will report regularly to the SFCCN.

It is the responsibility of UMBH to coordinate care during inpatient admissions including pre-discharge planning and post-discharge follow-up. Enrollees that are treated in an inpatient setting will receive continued services after discharge from an outpatient UMBH Network provider. The treating provider at the outpatient facility may not be the same provider as the treating provider from the inpatient setting, but communications and coordination of care will involve the Primary Care Provider (PCP). The PCP will also be involved in maintaining the continuity of care of enrollees requiring Behavioral Health Services coordination. Enrollees must sign a release of information prior to any information being transmitted or released by a facility or provider relating to an enrollee receiving Behavioral Health Services.

The PCP will be involved in maintaining the continuity of care of enrollees requiring Behavioral Health Service coordination.

Enrollees must sign a release of information prior to any information being transmitted or released by a facility or provider relating to an enrollee receiving Behavioral Health Services.

**PLEASE NOTE: ON THE SFCCN ENROLLEE'S ID CARD, THE APPLICABLE PHONE NUMBER FOR INPATIENT BEHAVIORAL HEALTH SERVICE AUTHORIZATION IS INDICATED.**

## **ENROLLEE SELF REFERRAL FOR CHIROPRACTIC, DERMATOLOGIC AND PODIATRIC SERVICES**

Enrollees may self refer without authorization to contracted, in-network chiropractic, dermatological, podiatric providers as described below:

- chiropractic- up to ten (10) visits per calendar year. Total visits (authorized and direct access capped by Medicaid at 24 visits per calendar year.
- dermatology- may direct access provider for office visits, minor surgical procedures and testing for up to five (5) office visits per calendar year. Any other services require PSN authorization.
- podiatry- may direct access provider for up to four (4) visits per calendar year. Services for procedures/surgeries will require PSN authorization in addition to compliance with Medicaid coverage and limitation guidelines.

Directly accessed chiropractic, dermatologic and podiatric providers are required to submit claims to the SFCCN Subnetwork of the enrollees for review and processing.

## **OUT OF SERVICE AREA MEDICAL NEEDS**

Procedures/services that are requested out of the service area must be pre-certified and deemed medically necessary by the Utilization Management Department of each Subnetwork. At the time of the referral to the Utilization Management Department, the supporting documentation must accompany the referral request. Emergency room requests will be authorized and reviewed retrospectively from claims data by each Subnetwork's Medical Director.

All Out-of-Service area requests for service will be reviewed and determinations on delivery of care will be made by the Medical Director of each Subnetwork.

Out-of-Service area authorizations will be determined by the availability of services offered within the network and medical necessity.

## **MEDICAID HANDBOOKS AND OTHER RESOURCES**

The Florida Medicaid program has many handbooks available to providers to assist in delineating coverage benefits and limitations which SFCCN providers are responsible for following. These handbooks may be accessed online at: [www.floridamedicaid.consultec-inc.com](http://www.floridamedicaid.consultec-inc.com) [then to Provider Support, then to Handbooks] or they can be purchased from the Medicaid fiscal agent, (ACS). These handbooks include immunization schedules, footnotes and applicable forms required by Medicaid.

Provider Support lines and resources currently available for Medicaid and MediPass providers remain available to you through the Medicaid fiscal agent (ACS) and the Agency for Health Care Administration.

In the SFCCN Program, all Medicaid handbooks and other benefits and limitations are applicable.

If a primary care provider desires to get his/her enrollment (patient panel) listing electronically via the Internet, complete the "Data Exchange Internet Access Request Form" (form provided earlier in this manual) and mail to ACS at the address noted.

## **MEDICAID WAIVER PROGRAMS**

- Aged/Disabled Adult Waiver
- Assisted Living for the Elderly Waiver
- Channeling Waiver
- Consumer-Directed Care Research and Demonstration Waiver
- Developmental Services Waiver
- Model Waiver
- Project AIDS CARE Waiver
- Supported Living Waiver
- Traumatic Brain Injury/Spinal Waiver
- Adult Cystic Fibrosis Waiver
- Nursing Home Diversion Waiver
- Family Planning Waiver
- Sub-Acute Inpatient Psychiatric Waiver

\*The Florida Medicaid Program has waiver services that a Medicaid beneficiary (including those in the PSN) may qualify for. These services provide benefits in addition to standard Medicaid (PSN) benefits.

The SFCCN does not manage these services. You may contact the local Medicaid Office for additional information if you believe a SFCCN enrollee may benefit from any of the programs. Program descriptions follow.

Providers are requested to notify SFCCN Case Management at the applicable Subnetwork of current waiver program participants in order to coordinate services and prevent duplication of services. In addition, waiver service providers are to send claims for waiver services directly to the Medicaid fiscal agent.

10/03 \*\*Pending updating for current waiver program revisions 4/1/06

# *CASE MANAGEMENT*

## **CASE MANAGEMENT**

The Agency for Health Care Administration (AHCA) defines case management as the manner or practice of planning, directing and coordinating the health care and utilization of medical and allied services of Medicaid recipients. Case Management is a collaborative process. Nurses and other licensed healthcare professionals who staff the SFCCN's Case Management programs will assist primary care providers by facilitating the case management process. Collaborative case management ultimately leads to continuity of care and quality care for SFCCN enrollees.

### **CASE MANAGEMENT REQUIREMENTS SET FORTH BY AHCA:**

- Scheduling of an initial appointment with the PCP within 90 days of enrollment for the purpose of completing a health risk assessment.
- Appropriate referrals and scheduling assistance.
- Documentation in the enrollee's case management files of referrals and emergency room encounters.
- Coordinated hospital/institutional discharge planning that includes post-discharge care.
- Monitoring of enrollees with ongoing medical conditions specifically developmental disabilities, behavioral health conditions and certain chronic diseases.
- Determining the need for non-covered services and referring the enrollee for assessment and referral to the appropriate service setting.

### **SFCCN CASE MANAGEMENT STAFF WILL SUPPORT PROVIDERS AND THEIR OFFICE STAFF IN MEETING THESE REQUIREMENTS BY:**

- Notifying the PCP of admissions, discharges, arrangements for post-discharge care and emergency department visits by phone or fax.
- Authorizing & coordinating the provision of durable medical equipment, medical supplies, home health care services, and prosthetics and orthotics.
- Requesting a release from the enrollee or the parent/legal guardian to contact developmental and behavioral health service providers and participate in coordinating their care.
- Referring enrollees with diabetes, asthma and/or AIDS to the appropriate disease management program within the SFCCN.
- Referring enrollees or providers to community resources or the Area Medicaid Office for assistance when an identified need is a non-covered item or service under the Medicaid program.

### **KEY COMPONENTS OF THE CASE MANAGEMENT PROCESS:**

- Initial contact with new enrollees for completion of a health risk assessment.
- Early identification and referral of enrollees with special needs.
- Follow-up after hospitalization or emergency department care.
- Coordination of home health services & durable medical equipment.
- Referral of enrollees who qualify to SFCCN disease management programs.
- Referral to community resources for non-covered services.

# **MATERNAL/CHILD CASE MANAGEMENT**

Maternal/Child Case Management Program is committed to providing the highest level of quality care for pregnant enrollees and their babies. The Maternal/Child Case Management Program is dedicated to continually improving and enhancing its services to mothers and babies.

The Maternal/Child Case Management Program is staffed by registered nurses. Once the enrollee is diagnosed with a positive pregnancy test or presents to her primary care provider for a first time prenatal visit, the enrollee shall be referred to a participating obstetrician or certified nurse midwife. The primary care provider's office is to notify the SFCCN Subnetwork Case Management Program of the pregnant enrollee. A list of participating obstetrical providers is available in the SFCCN Provider Directory.

SFCCN enrollees are required to use network obstetrical providers. Upon notification of a pregnant enrollee, the SFCCN Subnetwork Utilization Management Department will issue a block authorization for maternity care that will cover:

- prenatal care with lab work
- one ultrasound
- contracted hospital or contracted birthing center for delivery
- emergency room visits for labor checks
- one postpartum visit (GYN exam and voluntary family planning)

Additional ultrasounds, emergency room visits or an admission other than for delivery must be authorized by the SFCCN Subnetwork's Utilization Management Department with a separate authorization number.

Once notification of the pregnant enrollee has occurred, the SFCCN Subnetwork Maternal/Child Case Manager shall provide the enrollee with prenatal educational material including AHCA required materials and educational materials for mother and infant including infant care. A first contact will be made by phone or by mail to notify enrollee of the availability of that Subnetwork's Maternal/Child Case Management and obstetrical services. The enrollee will be followed by the SFCCN Subnetwork Maternal/Child Case Manager until her six-week postpartum check-up and her newborn's four week well baby exam are completed. Follow-up contact will be made if the infant has an emergency room visit or hospital admission before the first well baby visit.

## **THE SFCCN SUBNETWORK MATERNAL/CHILD CASE MANAGER WILL:**

- Refer and assist in the scheduling of obstetrical care/transportation services.
- Follow the enrollee throughout her pregnancy and assist enrollee as needed.
- Assist the enrollee with choosing a participating hospital for her delivery.
- The obstetrician of emergency room visits and follow-up with enrollee.
- Assist the enrollee in choosing her newborn's pediatrician or appropriate primary care provider by the enrollee's seventh month of pregnancy.
- Assist the enrollee in enrolling in Childbirth Education, breast feeding, family planning and other classes.

**ALL PREGNANT ENROLLEES WILL REQUIRE THE FOLLOWING SERVICES BY THE PRIMARY CARE OR OBSTETRICAL PROVIDER'S OFFICE:**

- WIC referral/nutritional counseling
- Florida Healthy Start Prenatal Risk Screening
- Prenatal Risk Assessment
- HIV pre-counseling and offering of HIV testing
- Hepatitis B surface antigen (HbsAg) screening
- Mental Health Services/Substance Abuse Treatment

**ONCE THE ENROLLEE GIVES BIRTH, THE MATERNAL/CHILD CASE MANAGER WILL:**

- Assist with the scheduling of postpartum and newborn follow-up visits before or soon after hospital discharge.
- Concurrently review the care of infants remaining hospitalized after the mother's discharge.
- Provide the enrollee with a postnatal packet including postpartum and newborn educational material.
- Assist the enrollee in obtaining referrals to WIC for self and infant, for breastfeeding education and support, and for nutritional services counseling.
- Be available to enrollee for questions about postpartum and newborn care.

To refer enrollees for Maternal/Child Case Management services, please refer to the contact list at the front of this manual.

## HEALTH RISK ASSESSMENT

The SFCCN mails a “Welcome” packet to all new enrollees who join the SFCCN on a monthly basis. The packet will contain, among other things, a “Health Risk Assessment” for the enrollee to complete and return to the SFCCN in a postage paid, self-addressed envelope that will be provided in the packet as well. The completed assessments will go directly to the Case Management Departments of the Subnetworks.

Subnetwork Case Managers will screen the assessments to identify enrollees who require case management services or who could benefit from a SFCCN Disease Management program. In addition, individuals with special health needs and related care coordination needs will be identified. The Case Manager will complete the appropriate referrals to initiate case or disease management for the enrollee. The Case Manager or Disease State Manager assigned to the enrollee’s case will contact the primary care provider to initiate a plan of care. The original assessment form will be mailed to the primary care provider for his/her review and placement in the enrollee’s medical record. The forms are color coded for your easy identification; the English version is green and the Spanish version is peach. One form is used for either a pediatric or adult enrollee. The SFCCN’s health risk assessment does not take the place of the primary care provider’s health risk assessment.

SFCCN providers may use this Health Risk Assessment tool or perform their own health risk assessment during the initial appointment with new enrollees to meet the ACHA and SFCCN contractual requirement of performing a Health Risk Assessment within the first 90 days of enrollment. The purpose of the health risk assessment is early identification of enrollees who need case/disease management and the identification of enrollees who are behind in periodicity screening as delineated by the Child Health Check-Up (formerly EPSDT) screening guidelines.

A blank copy of the “Health Risk Assessment” forms is available for your reference on the next page.

# ***DISEASE MANAGEMENT***

## **DISEASE MANAGEMENT**

The South Florida Community Care Network defines disease management as a comprehensive, integrated approach to care that focuses on both clinical and non-clinical interventions when and where they are likely to have the most impact. It is proactive and preventive in nature and engages the enrollee as a partner of the healthcare team. The SFCCN will work with providers and enrollees to improve clinical outcomes and system efficiencies. The goal is health management and illness avoidance as well as improved adherence to your (the physician's) treatment plan.

### **PROGRAM:**

Disease management is a collaborative process that facilitates the development and implementation of appropriate courses of care (based on clinical practice guidelines) to meet an enrollee's health care needs. Standardized programs for asthma, diabetes, hypertension, congestive heart failure, and HIV/AIDS has been developed for use across the three Subnetworks. These programs include, but are not limited to, practice guidelines, enrollee education, provider education, and performance improvement measures. Additional Disease Management Programs may be developed for other chronic illness as the need is identified. Those enrollees who would benefit from interaction with a Case Manager, but do not qualify for inclusion in established Disease Management Programs may be case managed at the Subnetwork level, as appropriate. Enrollees can be referred by a primary care provider, or can self-refer.

The disease management model provides a visual representative of the South Florida Community Care Network Disease Management Program. (See attachment A)

### **PCP ROLE:**

- Primary responsibility for medical management of enrollee;
- Identify and refer of appropriate enrollees;
- Ensure knowledge and implementation of accepted guidelines;
- Interact with care manager to develop plan of care;
- Monitor enrollee progress toward expected outcomes;
- Assist in education and adherence monitoring with care manager and disease management program staff to develop performance improvement strategies and plans;
- Maintain accurate and complete medical records.

### **DISEASE MANAGER'S ROLE:**

- Assess each referred enrollee and risk stratify him/her;
- Develop a plan of care based upon the assessment and risk stratification in conjunction with the PCP;
- Educate the enrollee;
- Provide referrals to Subnetwork and community resources;
- Educate providers and their office staff;
- Monitor enrollee adherence to plan of care;
- Monitor enrollee outcomes;
- Serve as a resource for benefit interpretation;
- Facilitate and coordinate care.

Please note that SFCCN enrollees may have participated in other disease management program. They will now be part of the SFCCN Disease Management Programs and the SFCCN Care Managers will assist in the transition.

**TO REFER ENROLLEES TO THE DISEASE MANAGEMENT PROGRAM, PLEASE UTILIZE THE FOLLOWING CONTACT INFORMATION:**

**Public Health Trust (Jackson Memorial Hospital)**

Disease Management Department  
(305) 585-8070  
(305) 585-5318 FAX

**North Broward Hospital District**

Disease Management Department  
(954) 767-5614  
(954) 767-5565 FAX

**Memorial Healthcare System**

Disease Management Department  
(954) 276-3131  
(954) 602-2863 FAX

# QUALITY MANAGEMENT

# SFCCN QUALITY MANAGEMENT PROGRAM

The South Florida Community Care Network (SFCCN) has as its mission to improve the quality of care to Medicaid recipients within a managed care system of delivery, to provide a high standard of health care and education, to improve the health status of the community, and to have satisfied enrollees and providers. We believe that this can best be accomplished with each enrollee having a Primary Care Provider as this fosters continuity of care. To accomplish this, a comprehensive Quality Improvement Program has been developed.

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

- Breast Cancer Screening
- Child Health Check-Up\*
- Cervical Cancer Screening\*
- Childhood Immunization Status\*
- Adolescent Immunization Status\*
- Well Child 1st 15 Months\*
- Well Child Years 3-6\*
- Adolescent Well Care\*
- # Enrollees Admitted to State Mental Hospital
- F/U After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Use of Appropriate Rx in Asthma
- Controlling HBP
- Comprehensive Diabetes Care (w/BP)\*
- Adults Access to Preventive/Ambulatory Health Services
- Annual Dental Visits
- Prenatal & Postpartum Care
- Frequency of Ongoing Prenatal
- Ambulatory Care (Includes ER measure)
- Mental Health Utilization-Inpt D/C & Avg LOS
- Mental Health Utilization-Inpt, Intermediate & Ambulatory Services
- Access/Availability
- Enrollee Satisfaction
- Provider Satisfaction
- Pediatric Preventive Care\*
- Adult Preventive Care\*

*\*REFER TO THE SFCCN PREVENTIVE HEALTH GUIDELINES*

## ENROLLEE AVAILABILITY/ACCESSIBILITY TO SERVICES

South Florida Community Care Network providers are required to meet the following access to care standards:

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

## **THE SCOPE OF THE QUALITY MONITORING PROGRAM INCORPORATES:**

- The generation of utilization reports for services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies, durable medical equipment companies, and pharmacies
- Facility audits and medical record reviews to monitor services provided by PCP's and high volume specialists
- Monitoring practice guidelines through medical record reviews and utilization reports
- The monitoring of high volume/high risk services based on review of demographic and epidemiological distribution of enrollees
- Review of acute and chronic care services
- Continuity and coordination of care
- Over and under utilization of medical resources
- Provider and enrollee satisfaction surveys
- Complaint and grievance monitoring and analysis
- Compliance with practice guidelines including preventive health guidelines

## **AFTER HOURS AVAILABILITY/ CALL COVERAGE**

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

## **RECREREDENTIALING PROCESS**

The SFCCN will recredential providers at two year or three year intervals. Refer to the SFCCN Health System with whom you are contracted (PHT, NBHD, MHS) for specific requirements. In addition to being in good standing with the Agency for Health Care Administration, the Subnetwork credentialing process will review applicants for recredentialing using their achievement of quality indicators, compliance with medical record standards, conformity to access and site maintenance standards, grievance trending, peer review outcomes, and utilization management practices and the state of Florida diabetic care guidelines.

## **MEDICAL RECORD DOCUMENTATION STANDARDS**

The following medical record standards apply to each enrollee's record:

- Each record must contain identifying information on the enrollee, including name, enrollee identification number (Medicaid #), date of birth and sex; and legal guardianship.
- Each record must be legible and maintained in detail.
- Each record must contain a summary of significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medications.
- All entries in each record must be dated and signed.
- All entries in each record must indicate the chief complaint or purpose of the visit; the objective findings of practitioner, diagnosis, or medical impression.
- All entries in each record must indicate studies ordered, for example: lab, x-ray, EKG, and referral reports.
- All entries in each record must indicate therapies administered and prescribed.
- All entries in each record must include the name and profession of practitioner rendering services, for example: M.D., D.O., O.D., including signature or initials of practitioner.
- All entries in each record must include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up, and outcome of services.
- Each record must contain an immunization history.
- Each record must contain information on smoking/ETOH (ethyl alcohol)/substance abuse.
- Each record must contain a record of emergency care and hospital discharge summaries.
- All records must reflect the primary language spoken by the enrollee and translation needs of the enrollee.
- All records must identify enrollees needing communication assistance in the delivery of health care services.
- All records must contain documentation that the enrollee was provided written information concerning the enrollee's rights regarding advanced directives (written instructions for living will or power of attorney), and whether or not the enrollee has executed an advanced directive. The provider shall not, as a condition of treatment, require the enrollee to execute or waive an advanced directive in accordance with Section 765.110, F.S.

## **PEER REVIEW**

It is the intent and purpose of the South Florida Community Care Network to continually improve the quality of the level of care and service provided to the SFCCN enrollee. The methodology to achieve this goal is based on establishing standards and performance goals for the delivery of care, services measuring performance outcomes and taking appropriate interventions to improve the outcomes. Clinical indicators called Generic Outcome Screen Indicators (GOSI), medical record standards and preventive health initiatives have been established and reviewed by a committee of physician providers. The GOSI which are attached will be utilized to review medical cases for the appropriateness of diagnosis and corresponding treatment, unexpected outcomes including mortality and morbidity, in addition to complications from surgery for both elective and emergent conditions. Enrollee satisfaction surveys, complaint and grievance monitoring and analysis, and finally, compliance with disease management program guidelines are reviewed along with the other standards previously mentioned and are used to assess the performance of all primary care providers, including: Family Physicians, Internists, General Practitioners, Pediatricians, Obstetrician/Gynecologists and Advance Registered Nurse Practitioners (ARNP).

At each Subnetwork (North Broward Hospital District, Memorial Healthcare System, and the Public Health Trust of Dade County) peer review responsibilities reside in a committee or committees of licensed physicians who are members of the physician network of that specific hospital district. Responsibilities minimally include:

1. Review of credentialing and re-credentialing applications

2. Conformance with the SFCCN's standards for availability and maintenance of medical records
3. Preventive care guideline compliance
4. Enrollee access to services
5. Enrollee grievances
6. Quality of care and services
7. Coordination of care and services

The SFCCN's Subnetwork's actions for unacceptable performance will increase in severity ranging from the tracking and trending of provider practices using available data sources, suspension of additional assignment/enrollment of new enrollees, to the transfer of enrollees to another physician provider and/or the termination of privileges under the SFCCN contract. Whenever an action must be taken immediately in the best interest of patient care, a provider's contract can be summarily suspended.

When a provider has his/her (1) Florida license, (2) DEA number, (3) Medicaid/MediPass or (4) Medicare Provider numbers revoked or suspended, he/she must **IMMEDIATELY** notify the Subnetwork of the SFCCN. The revocation or suspension of any of the above licenses or numbers will lead to an automatic suspension of the provider's SFCCN contract. The provider may re-apply to become a SFCCN provider, if and when, the revoked or suspended license or number is reinstated.

There will be a process in place that will offer the provider several levels of appeals within the Subnetwork. The appellate process may be initiated by the provider contacting the Medical Director or Executive Director of the Subnetwork. The final level of appeal will reside within the appellate system already in place at each of the SFCCN Subnetworks hospital systems. The SFCCN will be responsible for reporting adverse peer review determinations to the National Practitioner's Data Bank and the State of Florida Medicaid Program. Such determinations may result in the loss of status in the SFCCN either on a temporary or on a permanent basis.

The Agency for Health Care Administration, which will be providing oversight for this program, will be receiving SFCCN quality indicator outcome reports as defined in the quality management section of this manual. The SFCCN in turn will be closely monitoring minimally these same quality indicators and the Generic Outcome Indicators in order to evaluate the performance of providers.

## **CHILD HEALTH CHECK-UP**

Primary Care Providers must participate in activities for Child Health Check-Up (also known as EPSDT), including timely provision of services required by the State of Florida periodicity schedule. The Child Health Check-Up program is a preventive and comprehensive service for eligible children birth through 20 years of age and for children in the MediKids program.

The Child Health Check-Up program provides for regular health check-ups that include a comprehensive health and developmental history (including assessment of behavioral health status); a comprehensive physical exam; nutritional and developmental assessment; vision, hearing and dental screenings; lab tests (including testing for lead poisoning); appropriate immunizations (shots); health education/anticipatory guidance; diagnosis and treatment; and referral and follow-up, as needed.

Eligible children and young adults should have a health check-up at birth; 2-4 days for newborns discharged in less than 48 hours after delivery; by 1 month; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; and once every year for ages 2-20. Individuals may also request a Child Health Check-Up at other times if they think their child needs it. Additional information on this quality and preventive health activity is available upon request.