Provider Manual

3.27.2024

1643 Harrison Parkway, Building H, Suite 200

Sunrise, Florida 33323

www.CCPcares.org

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WELCOME

We are pleased to welcome you as a network provider in the Community Care Plan (CCP) Provider Service Network (PSN). CCP has entered into a contract with the State of Florida Agency for Health Care Administration (AHCA) to provide Medicaid services to eligible Medicaid beneficiaries as a Provider Service Network (PSN). Since 1970, Florida Medicaid has provided healthcare coverage for income-eligible children, seniors, disabled adults, and pregnant women. It is funded by both the state and federal governments. You have chosen to become a provider of this unique network. Together, we will work with you as a team, bringing our individual expertise to achieve the high standards our community expects.

In October 2013, CCP was awarded by the State of Florida Agency for Health Care Administration (AHCA) to provide Medicaid services in the Statewide Medicaid Managed Care Program (SMMC) to eligible Medicaid beneficiaries in Broward County as a capitated Provider Service Network (PSN). The Statewide Medicaid Managed Care Program (SMMC) is a program authorized by the 2011 Florida Legislature through House Bill 7107, creating Part IV of Chapter 409, F.S., to establish the Florida Medicaid Program as a statewide, integrated managed care program for all covered services, including long-term care services.

You have committed to delivering quality medical care to CCP enrollees. This Provider Manual answers many of your questions about CCP 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 Community Care Plan. 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 CCP 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 through newsletters and bulletins.

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

Thank you,

Community Care Plan

IMPORTANT CONTACTS

Community Care Plan MMA	
Community Care Plan 1643 Harrison Parkway Building H, Suite 200 Sunrise, Florida 33323	
Provider Operations	**Member Services**
Phone: 1-855-819-9506 Email: ccp.provider@ccpcares.org	Phone: 1-866-899-4828
Case Management	**Disease Management**
Phone: 1-866-899-4828	Phone: 1-866-899-4828
Claims/Billing	
Electronic Claims: Community Care Plan (CCP) Availity Payer ID: 59065	Claims with attachments should be mailed to: CCP Claims Department PO BOX 841309 Pembroke Pines, FL 33084
Claim Timely Filing	**Claims Inquiries**
180 days from date of service or date	Phone: 1-866-899-4828
Prior Authorization Inquiries	**Fraud & Abuse Hotline**
Phone: 1-866-899-4828	Phone: 1-888-419-3456
Web Portal- Plan Link	**Emergency 24/7 Behavioral Health Crisis**
http://planlink.ccpcares.org/	Phone: 877-400-4999
Vendors	
Pharmacy	Magellan Pharmacy Solution 1-800-424-7897
DME	Coastal 833-204-4535
Home Health	Coastal 833-204-4535
PT, OT, ST	Health Network One (HN1) 888-550-8800 Option 2
Vision	South Florida Vision/2020/iCare 1-877-296-0799
Transportation	ModivCare 1-866-306-9358
Crisis Hotline	2-1-1 Broward 954-372-1737

CLAIM ADDRESSES

ELECTRONIC CLAIMS:
Availity, Payer ID 59065

PAPER CLAIMS:
Community Care Plan
P. O. BOX 841309
Pembroke Pines, FL 33084

PROVISION OF SERVICES

CCP covered services are provided in accordance with the Florida Medicaid State Plan and are required to be medically necessary as defined in the Florida Medicaid Provider General Handbook. These services are provided up to the coverage limits specified by the Medicaid program, which can be found in the respective Florida Medicaid Coverage and Limitations Handbooks and Medicaid Fee Schedules at:
http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx

CLAIMS FILING GUIDELINES

Claims	Timely Filing Guideline
Plan Participating Providers	Provider shall mail or electronically transfer (submit) all claims within 60 days of the date of service (DOS). Claims submitted after a 180-day period from the date of service will automatically be denied by CCP for untimely filing.
Non-Participating Providers	Provider shall mail or electronically transfer (submit) the claim within 365 days from the date of service (DOS).
Plan as Secondary Payor	When the Managed Care Plan is the secondary payer, the provider must submit the claim to CCP within **ninety (90) calendar days** from the date of the final determination of the primary payer.
Medicare Crossover	When the Managed Care Plan is the secondary payer to Medicare, and the claim is a Medicare cross over claim, these must be submitted within **36 months** of the original submission to Medicare.
Corrected Claims	Claims appeals must be submitted using the CCP request for Reconsideration Form within 60 days from date of denial.
Return of requested additional information (itemized bill, ER records, med records, attachments)	Claims appeals must be submitted using the CCP request for Reconsideration Form within 60 days from date of denial.

APPEALS FILING GUIDELINES

Claims	Par/Non-Par	Timely Filing Guideline
Provider Appeals related to Medical Necessity	Par/Non-Par	30 days from Explanation of Benefits/ Explanation of Payment/Remit
Provider Appeals related to billing disputes, not related to authorizations The exception to this is underpayment disputes: they all have 365 days to dispute	Par/Non-Par	30 days from Explanation of Benefits/ Explanation of Payment/Remit
Provider Appeals-claim appeals (related to authorization) Requesting authorization after the claim is filed and EOB went out stating claim was denied for no authorization	Par/Non-Par	30 days from Explanation of Benefits/ Explanation of Payment/Remit

MMA COVERED SERVICES (2019 - 2023)

Service	Description	Coverage/Limitations	Prior Authorization
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us	Plan OK Needed
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover blood or skin allergy testing and up to 156 doses per year of allergy shots No copayment	Plan OK Needed
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary	No Plan OK Needed
Ambulatory Detoxification Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	As medically necessary and recommended by us	Plan OK Needed
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary	Plan OK Needed
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary	No Plan OK Needed

Service	Description	Coverage/Limitations	Prior Authorization
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year	No Prior Authorization is required when services are rendered in an Assisted Living Facility, Adult family care home, or Residential treatment facility
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover: - One initial assessment per year - One reassessment per year - Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day) No copayment	No Authorization for initial 15 hours
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program	We cover 365/366 days of services per year, including therapy, support services and aftercare planning	Plan OK Needed for certain services
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor: - Cardiac testing - Cardiac surgical procedures - Cardiac devices - No copayment	Plan OK Needed for certain invasive services.
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services	Your child must be enrolled in the DOH Early Steps program	No Plan OK Needed

Service	Description	Coverage/Limitations	Prior Authorization
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover: - 24 established patient visits per year, per member - X-rays - No copayment	Plan OK Needed after 24 visits per year, up to a maximum of 37 visits.
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic	No copayment	No Plan OK Needed
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	- As medically necessary and recommended by us	No
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor: - Hemodialysis treatments Peritoneal dialysis treatments	Plan OK Needed
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	Some service and age limits apply. Call 1-866-899-4828 for more information.	Prior Authorization is required for some Durable Medical Equipment and Medical Supplies

Service	Description	Coverage/Limitations	Prior Authorization
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions	We cover: - One initial evaluation per lifetime, completed by a team - Up to 3 screenings per year - Up to 3 follow-up evaluations per year - Up to 2 training or support sessions per week	No Plan OK Needed
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary	No Plan OK Needed
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover: - One adult health screening (check-up) per year - Well child visits are provided based on age and developmental needs - One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions - No copayment	No Plan OK Needed
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover: - Up to 26 hours per year - No copayment	No Plan Ok Needed for up to 9 hours
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: - Covered as medically necessary - No copayment	Plan OK Needed for invasive procedures.
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: - Covered as medically necessary - No copayment	Plan OK Needed for invasive procedures.
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover: - Up to 39 hours per year - No copayment	No Plan OK Needed for up to 9 hours

Service	Description	Coverage/Limitations	Prior Authorization
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor: - Cochlear implants - One new hearing aid per ear, once every 3 years - Repairs	Plan OK Needed for Cochlear implants.
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	We cover: - Up to 4 visits per day for pregnant recipients and recipients ages 0 - 20 - Up to 3 visits per day for all other recipients - No copayment	Plan OK Needed
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	- Covered as medically necessary - Copayment: See information on Patient Responsibility for copayment information; you may have Patient Responsibility for hospice services whether living at home, in a facility, or in a nursing facility	Plan OK Needed
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover: - Up to 26 hours per year - No copayment	No Plan OK Needed
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation: - Up to 365/366 days for recipients ages 0 - 20 Up to 45 days for all other recipients (extra days are covered for emergencies)	Plan OK Needed
Integumentary Services	Services to diagnose or treat skin conditions, illnesses, or diseases		Plan OK Needed for invasive procedures.

Service	Description	Coverage/Limitations	Prior Authorization
Laboratory Services	Services that test blood, urine, saliva, or other items from the body for conditions, illnesses, or diseases	- Covered as medically necessary - No copayment	Plan OK Needed for genetic testing.
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families	No Plan OK Needed
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	- Covered as medically necessary - No copayment	No Plan OK Needed
Medication Management Services	Services to help people understand and make the best choices for taking medication	- Covered as medically necessary - No copayment	No Plan OK Needed
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	No Plan OK Needed
Neurology Services	Services to diagnose or treat conditions, illnesses, or diseases of the brain, spinal cord, or nervous system	- Covered as medically necessary - No copayment	Plan OK Needed for some procedures
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: - Out-of-state travel - Transfers between hospitals or facilities - Escorts when medically necessary - No copayment	No Plan OK Needed
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term	We cover 365/366 days of services in nursing facilities as medically necessary Copayment: See information on Patient Responsibility for room & board copayment information	Plan OK Needed
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in	We cover for children ages 0-20 and for adults	Plan OK Needed

Service	Description	Coverage/Limitations	Prior Authorization
	your daily life, like writing, feeding yourself, and using items around the house	under the $1,500 outpatient services cap: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	- Covered as medically necessary - No copayment	Plan OK Needed for some procedures
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	- Covered as medically necessary - No copayment	Plan OK Needed for Invasive procedures and advanced imaging services (such as MRI or CAT scan)
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	- Emergency services are covered as medically necessary - Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over - No copayment	Plan OK Needed for some invasive procedures and overnight hospital observation

Service	Description	Coverage/Limitations	Prior Authorization
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	- Covered as medically necessary. Some service limits may apply - No copayment	Plan OK Needed for Invasive procedures
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Plan OK Needed except for initial evaluation and re-evaluations
Podiatry Services	Medical care and other treatments for the feet	We cover: - Up to 24 office visits per year - Foot and nail care - X-rays and other imaging for the foot, ankle, and lower leg - Surgery on the foot, ankle, or lower leg - No copayment	Plan OK Needed for Invasive surgery
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover: - Up to a 34-day supply of drugs, per prescription Refills, as prescribed	Some medications require Prior Authorization. All covered medications are $0 copay.
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover: Up to 24 hours per day	Plan OK Needed
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ, or other areas	We cover: - 10 hours of psychological testing per year - No copayment	No Plan OK Needed

Service	Description	Coverage/Limitations	Prior Authorization
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover: - Up to 480 hours per year - No copayment	No Plan OK Needed for up to 240 hours
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs, or CAT scans. They also include portable x-rays	- Covered as medically necessary - No copayment	Plan OK Needed for advanced imaging such as MRI or CAT scans. No Plan OK Needed for x-rays
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary	No Plan OK Needed
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	No Plan OK Needed
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover: - Respiratory testing - Respiratory surgical procedures - Respiratory device management - No copayment	Plan OK Needed for some invasive procedures and devices.

Service	Description	Coverage/Limitations	Prior Authorization
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness, or disease	We cover: - One initial evaluation per year - One therapy re-evaluation per 6 months - Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	Plan OK Needed except for initial evaluation and re-evaluations.
Specialized Therapeutic Services	Services provided to children ages 0 - 20 with mental illnesses or substance use disorders	We cover the following: - Assessments - Foster care services - Group home services	Plan OK Needed
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following services for children ages 0 - 20: - Communication devices and services - Up to 210 minutes of treatment per week - One initial evaluation per year We cover the following services for adults: One communication evaluation per 5 years	Plan OK Needed except for initial evaluation and re-evaluations
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0 - 20	Plan OK Needed
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover: - Up to 9 hours per month - No copayment	No Plan OK Needed
Transplant Services	Services that include all surgery and pre- and post-surgical care	Covered as medically necessary	Plan OK Needed

Service	Description	Coverage/Limitations	Prior Authorization
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following services when prescribed by your doctor: - Two pairs of eyeglasses for children ages 0 - 20 - Contact lenses Prosthetic eyes	Please contact 20/20 for Authorization at 1-877-296-0799
Visual Care Services	Services that test and treat conditions, illnesses, and diseases of the eyes	- Covered as medically necessary - No copayment	Please contact 20/20 for Authorization at 1-877-296-0799

APPROVED MMA EXPANDED BENEFITS

Unlimited Primary Care Visits (Non-Pregnant Adults)
Intensive Outpatient Treatment (Behavioral Health) • Unlimited at an in-network facility
Prenatal Services • Hospital Grade Breast Pump -Max of one per year (rental PA is required) • Breast Pump -1 per 2 years (rental, no PA required) • Antepartum Management- 14 visits for low-risk pregnancies and 18 visits for high-risk pregnancies • Postpartum Care- 3 visits within 90 days following delivery
Medically Related Home Care Services/Homemaker • 2 carpet cleanings/year for enrollees with asthma
Acupuncture • 20 Units per Year; Must be diagnosed with chronic pain or cancer and the service be ordered by in-net Pain Management Specialist or Oncologist.
Chiropractic • 13 additional visits per year; Must be diagnosed with chronic pain or cancer and the service be ordered by in-net Pain Management Specialist or Oncologist.
Doula Services • Unlimited per pregnancy
Durable Medical Equipment • Hospital Bed – One (1) every five (5) years • Glucose Monitoring – No Limit – based on medical necessity criteria • Breast Pump – One (1) every four (4) years
Adult Pneumonia (Pneumococcal) Vaccine • Unlimited
Adult Influenza Vaccine • Unlimited
Adult Shingles (Varicella-Zoster) Vaccine • One (1) per year
Home Delivered Meals - Disaster Preparedness/Relief • One (1) annually
Home Delivered Meals - Post-Facility Discharge (Hospital or Nursing Facility) • Ten (10) meals annually
Home Visit by a Clinical Social Worker • 48 visits per year with prior authorization
Housing Assistance • $250 Lifetime; requires 6 months of consecutive enrollment
Non-emergency Transportation - Non-Medical Purposes • 2 one-way trips per month; 10 mile maximum one-way per trip

Nutritional Counseling • Unlimited
Meals - Non-emergency Transportation Daytrips • $150.00 per stay
Intensive Outpatient Treatment (Behavioral Health) • Unlimited at an in-network facility
Physical Therapy • Physical Therapy Evaluation, moderate Complexity 1 Per year • Physical Therapy Re-evaluation, 1 Per year • Physical Therapy Treatment Visit, up to 7 therapy treatment units per week
Occupational Services • Occupational Therapy evaluation moderate complexity- 1 per year • Occupational Therapy Re-evaluation- 1 per year • Occupational Therapy Treatment visit- up to 7 therapy treatment units per week
Respiratory Therapy • Initial Evaluation/Re-evaluation, 1 per year • Respiratory Therapy Visit, 1 per year
Hearing Services • Assessment for Hearing Aid- 1 per every 2 years • Hearing Aid Fitting/Checking- 1 per every 2 years • Hearing Aid Monaural in Ear- 1 per year • Behind Ear Hearing Aid- 1 per every 2 years • Hearing Aid Dispensing Fee- 1 per every 2 years • In Ear Binaural Hearing Aid- 1 per every 2 years • Behind Ear Binaur Hearing Aid- 1 per every 2 years • Dispensing Fee Binaural- 1 per every 2 years • Behind Ear Cros Hearing Aid- 1 per every 2 years • Cros hearing Aid Dispense Fee- 1 per every 2 years • Behind Ear Bicros Hearing Aid- 1 per every 2 years • Dispensing Fee Bicros- 1 per every 2 years • Hearing Evaluation- 1 per every 2 years

Vision Services • Contact lens, PMMA, spherical, per lens-6 Month Supply with Prescription • Contact lens, PMMA, toric or prism ballast, per lens-6 Month Supply with Prescription • Contact lens, gas permeable, toric, prism ballast, per lens-6 Month Supply with Prescription • Contact lens, gas permeable, extended wear, per lens-6 Month Supply with Prescription • Contact lens, hydrophilic, spherical, per lens-6 Month Supply with Prescription • Contact lens, hydrophilic, toric, or prism ballast, per lens-6 Month Supply with Prescription • Contact lens, hydrophilic, extended wear, per lens-6 Month Supply with Prescription • Contact lens, other type-6 Month Supply with Prescription • Frames-1 per year • Equipment-1 per year
Speech Therapy • Evaluation/Re-Evaluation/Evaluation of Oral & Pharyngeal Swallowing Function- 1 per day • Speech Therapy Visit- Up to 7 therapy treatment units per week • AAC Initial Evaluation-1 per day • AAC-Re-Evaluation- 1 per day • AAC Fitting, Adjustments, & Training Visit- Up to four 30-minute AAC fitting, adjustment, and training sessions/year
Massage Therapy • 8 Units (2 hours) per Month; Must be diagnosed with chronic pain or cancer and the service be ordered by an in-network Pain Management Specialist or Oncologist.
Equine Therapy • Up to 10 therapy treatment sessions per year for 21+ years old. • One evaluation/re-evaluation per year.
Medication Assisted Treatment • Unlimited for 21+ years old.
Newborn Circumcision • Available within the first (12) weeks of birth. • One (1) per lifetime.
Swimming Lessons • Members up to age 11 are covered for up to $200 per year. • This is limited to 1000 enrollees per year.
Vaccine – Tdap • One (1) vaccine per pregnancy

Primary Care Services • Office/Outpatient Visit Est – Unlimited • Nursing FAC Care Subseq – Unlimited • Prev Visit Est Age 18-39 – Unlimited • Prev Visit Est Age 40-64 – Unlimited • Per PM Re-eval Est Pat 65+ Yr – Unlimited
Psychosocial Rehabilitation • No Limit – based on medical necessity criteria
Biometric Equipment • 1 digital blood pressure cuff every 3 years with Prior Auth
Financial Literacy • Unlimited w/ Prior Auth
Targeted Case Management • No Limit – based on medical necessity criteria w/ Prior Auth
Therapeutic Behavioral On-Site Services • Maximum day limit (total of 10 hours per month.) w/ Prior Auth
Therapy – Art • No Limit – based on medical necessity criteria w/ Prior Auth
Therapy – Pet • No Limit – based on medical necessity criteria w/ Prior Auth
Therapy (Individual/Family) • Additional 2 visits per year with Prior auth
Tutoring K-12 • 2 hours per week with Prior Auth
Cellular Phone Service • 1 cellphone, 350 mins, Unlimited text, 16G Data w/ Prior Auth
Computerized Cognitive Behavioral Analysis • Unlimited w/ Prior Auth
Therapy (Group) • Unlimited w/ Prior Auth
Waived Copayments • All services.

Newly Covered Services:

(1) Nursing Facility Services
(2) EIS – Early Intervention Services

CODE	***DESCRIPTION***	***CODE***	***DESCRIPTION***
81	Professional Early Intervention Services	981	Professional Early Intervention Services
82	Para-professional Early Intervention Services	982	Para-professional Early Intervention Services

(3) MFC – Medical Foster Care Services

CODE	***DESCRIPTION***	***CODE***	***DESCRIPTION***
23	Medical Foster Care/ Personal Care Provider	923	Medical Foster Care/ Personal Care Provider

(4) TCM – Child Health Services Targeted Case Management

CODE	***DESCRIPTION***	***CODE***	***DESCRIPTION***
30	Nurse Practitioner (ARNP)	177	DOH/CMS/Medical Foster Care TCM
31	Registered Nurse First Assistant	177	DOH/CMS/Medical Foster Care TCM
32	Social Worker/Case Manager	176	DOH/CMS/TCM Infant and Toddler Developmental Services
32	Social Worker/Case Manager	177	DOH/CMS/Medical Foster Care TCM
91	Case Management Agency	176	DOH/CMS/TCM Infant and Toddler Developmental Services
91	Case Management Agency	177	DOH/CMS/Medical Foster Care TCM

DEFINITIONS

Medically necessary: Services that include medical or allied care, goods, or services furnished or ordered:

1. To meet the following conditions:
   a. Be necessary to protect life to prevent significant illness or significant disability or to alleviate severe pain
   b. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
   c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
   d. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
   e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker, or the provider
2. For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
3. The fact that a provider has prescribed, recommended, or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Well Child Visits (Child Health Check-Up) Services & Immunizations: A child health checkup is a routine health screening evaluation of children ages 20 and under that includes a comprehensive health and developmental history; hearing, vision, blood lead (ages 12 and 24 months) updating of routine immunizations; and referrals for further diagnosis and treatment as needed. Immunizations can be received at no charge through provider participation in the Vaccines for Children Program (VFC). The VFC program is administered by the Department of Health, Bureau of Immunizations. For more information about VFC, call 1-800-483-2543 or go to www.doh.state.fl.us/DISEASE_CTRL/immune/vfc/index.html.

Providers are encouraged to assist enrollees in the timely provision of these services as required by the State of Florida periodicity schedule. The Child Health Check-Up periodicity schedule is based on the American Academy of Pediatrics, you can assess it at: http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf

If you would like to learn more about the Florida Medicaid Child Health Check Up coverage ~~and~~ limitation, you can access the handbook at: http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Child_Health_Check-UpHB.pdf

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. Enrollee participation in Maternal/Child Case Management will assist a pregnant enrollee in obtaining all the services she needs to have a healthy pregnancy.

Emergency Care:
Emergency Services are those necessary to treat a condition, illness, or injury, which requires immediate attention. Enrollees should not be sent to the emergency room for the following conditions: routine follow-up care; follow-up for suture or staple removal and non-emergent care during normal business hours. Prior authorization is not warranted for emergency care service within the region or outside the region.

Hospital:
Hospital Inpatient Care includes all inpatient services authorized by CCP: room and board, nursing care, and medical supplies, diagnostic and therapeutic services. For adults 21 years of age and older, reimbursement for inpatient hospital care is limited to 45 days per Florida Medicaid's fiscal year (July 1 through June 30). There is no limit on the number of inpatient days for recipients 20 years of age and younger. 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. CCP enrollees will have behavioral health services managed by Community Care Plan.

Hearing and Vision Care Services:
Hearing services include hearing evaluation, diagnostic testing, and fitting of a hearing aid (one hearing aid every three years). Other hearing services may include cochlear implant services and newborn hearing screening. Vision services allowed by Medicaid include eyeglasses, eyeglass repairs as required, prosthetic eyes and contact lenses for eligible enrollees. Medicaid allows for two pairs of glasses per enrollee per year. Vision Services will be provided by South Florida Vision/2020/iCare, phone number 1-877-296-0799.

Family Planning:
The purpose of family planning services is to allow enrollees to make informed decisions about family size and/or spacing of births. Family planning services offered include information and referral, education and counseling, diagnostic testing, contraceptives, and follow-up care.

Non-Emergency Transportation:
CCP enrollees will have access to Non-Emergency Medical Transportation Services through CCP's transportation vendor, ModivCare. Enrollees can access these services without a co-pay. To coordinate non-emergency medical transportation for CCP Enrollees, contact ModivCare at 1-866-306-9358.

PROVIDER RESPONSIBILITIES

Providers who participate in CCP shall render medical care to enrollees of CCP, pursuant to all laws and regulations applicable to the Provider and CCP, including all requirements of the Florida Medicaid Program, the Florida Medicaid Coverage and Limitation Handbook, and the CCP Provider Manual.

PCP (PRIMARY CARE PROVIDER)

A primary care provider (PCP) is a health care practitioner who sees people that have common medical problems. This person is most often a doctor. However, a PCP may be a physician assistant or a nurse practitioner.

SKILLED NURSING FACILITIES

1. Day-to-Day Care Management: SNFs must ensure day-to-day care management that addresses the medical, nursing, mental, and psychosocial needs of enrollees while they are in the nursing facility. Care must be provided in accordance with individualized Plans of Care.
2. Participation in Transition Planning Process: SNFs must actively participate in the transition planning process for enrollees. This includes attending Transition Planning Process meetings and collaborating with the Medicaid Managed Care Plan Care Coordinator to assist enrollees in transitioning to lower levels of care when appropriate.
3. Participation in Multidisciplinary Team Meetings: SNFs are required to participate in multidisciplinary team meetings convened by the Medicaid Managed Care Plan Care Coordinator to ensure comprehensive and coordinated care for enrollees.
4. Assessment and Plan of Care: SNFs must conduct an initial assessment upon admission and subsequent assessments every twelve months, with reviews at least every 120 days or after a significant change in the enrollee's condition. Plans of Care must be developed by an interdisciplinary team and include objectives and timeframes to address enrollees' medical, nursing, mental, and psychosocial needs identified in the assessment.
5. Post-Discharge Plan of Care: SNFs must provide a comprehensive assessment of the enrollee's functional capacity and a post-discharge plan of care upon admission and quarterly as part of the Plan of Care. The post-discharge plan of care must outline plans, actions, and goals to transition the enrollee to a home and community-based, non-institutional setting.
6. Provision of Therapies and Enrichment Activities: SNFs must provide therapies and enrichment activities in accordance with the enrollee's individual needs and Plan of Care.
7. Compliance with PASRR Requirements: SNFs must comply with PASRR requirements in accordance with 42 CFR Part 483 and 59G-1.040m Florida Administrative Code. Completed PASRR assessments must be maintained in the enrollee's Nursing Facility record.
8. Utilization of Health Plan's Secure Provider Portal: SNFs are required to utilize the applicable health plan's secure Provider Portal for information-sharing related to the enrollee's health.
9. Communication with Medicaid Managed Care Plan Care Coordinator: SNFs must promptly communicate any changes in an enrollee's health status to the enrollee's Medicaid Managed Care Plan Care Coordinator.

10. Collaboration with the Public School System: For enrollees under 21 years of age, SNFs must collaborate with the public school system to ensure intellectual needs are met and age-appropriate educational programming is provided to enhance the enrollee's quality of life.
11. Inclusion of Enrollee and Family: SNFs must include the enrollee and family, at their option, as well as other members of the enrollee's care team in the development, implementation, maintenance, and evaluation of the enrollee's Plan of Care.
12. Instruction of Parents/Guardians/Authorized Representatives: SNFs must instruct or arrange for the instruction of parents, legal guardians, or other caretakers on how to provide necessary interventions and manage unexpected responses to facilitate a smooth transition from the Nursing Facility to the home.
13. Referral to Medicaid Managed Care Plan Care Coordinator: SNFs must direct the enrollee or parent/guardian/authorized representative to the Medicaid Managed Care Plan Care Coordinator for any roles, functions, or responsibilities described in the Medicaid Managed Care Plan Care Coordinator section.
14. Responsibilities: It is the responsibility of the Skilled Nursing Facility to ensure compliance with this policy and to provide necessary resources and training to staff to meet these requirements.

Enforcement: Failure to comply with the above requirements may result in corrective actions, up to and including termination of the agreement between the SNF and the health plan.

DISENROLLMENT

Community Care Plan must not restrict the Member's right to disenroll voluntarily in any way. Neither it, nor its subcontractors, providers or vendors shall provide or assist in the completion of a disenrollment request or assist the Agency's enrollment broker in the Disenrollment process. Members requesting disenrollment from Community Care Plan must be referred to the Agency. Providers should inform Community Care Plan in writing when a Member has been referred to the Agency's enrollment broker for disenrollment.

CCP SUBCONTRATORS RESPONSIBILITIES

Community Care Plan contracts with subcontractors to provide behavioral health services, pharmacy services, transportation services, and vision services. These subcontractors are responsible to manage the provisions of medically necessary services pursuant to CCP Administration Agreement, Florida Statute and the Florida Medicaid Coverage and Limitation Handbook. The contact information for all the subcontractors is listed in the Important Contacts section of this manual.

PROVIDER COMPLAINTS

Should a participating provider become dissatisfied with CCP's policies and procedures, or any aspect of CCP's administrative functions, including claims issues, the provider may file a complaint with Provider Relations. The provider may file a non-claim related complaint within forty-five (45) calendar days of the event.

CCP's dedicated Provider Relations Staff are available during regular business hours via telephone, electronic mail or in person to ask questions, file a complaint and/or resolve problems. The Provider Relations Staff will carefully record and thoroughly investigate each complaint according to the established procedure using applicable statutory, regulatory, contractual and provider contract provisions, and will collect all pertinent facts from all parties. The provider complaint will be review by the Provider Services Manager or Supervisor. Any complaints about claim issues will be review by the Claims Department Manager or Supervisor. Providers can call CCP's Provider Operations Department at 1-855-819-9506 to file any type of complaint including claims. The written complaint may be mailed to:

Community Care Plan
1643 Harrison Parkway, H-200
Sunrise, FL 33323
Attention: Provider Operations

If the compliant has not been resolved within 15 days of receipt, the provider will receive a written notice of the status of the review and will continue to receive updates every 15 days thereafter.

For provider complaints concerning non-claims issues, the Managed Care Plan shall:

(1) A response within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution.

(2) Resolution of all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

For provider complaints concerning claims issues, the following process shall be followed:

(1) Providers have ninety (90) days from the date of final determination of the primary payer to file a written complaint for claims issues.

(2) Within three (3) business days of receipt of a claim complaint, CCP will notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution.

(3) Within fifteen (15) days of receipt of a claim complaint, CCP will provide written notice of the status of the complaint to the Agency and the provider. For claims issues that require additional research, CCP Plan will submit a written request to the Agency within three (3) business days of receipt of the complaint, and it will include:

(a) An explanation for the need of an extension; and

(b) Expected time needed beyond the fifteen (15) days for research and response.

i) Approval of extension is contingent upon Agency review.

(ii) CCP will provide written notice of the status to the provider every fifteen (15) days thereafter; and

(4) CCP will, resolve all claims complaints within sixty (60) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

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

CONTINUITY OF CARE REQUIREMENTS FOR NEW ENROLLEES

CCP is dedicated to coordinated care for all new enrollees enrolled into the plan. The coordination of care ensures all new enrollees receiving medical treatment through a previous health plan or fee-for-service Medicaid continue to receive the same course of treatment, without any prior authorization requirements and without regard to whether such medical treatment is being provided by participating or non-participating provider.

During the first thirty (30) days of an enrollee in the plan, CCP will reimburse non-participating providers the rate they received for services prior to enrolling in CCP.

CCP will provide continuation of services until the enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively), reviews the new enrollee's treatment plan. The continuation of care shall be no more than sixty (60) calendar days after the effective date of enrollment.

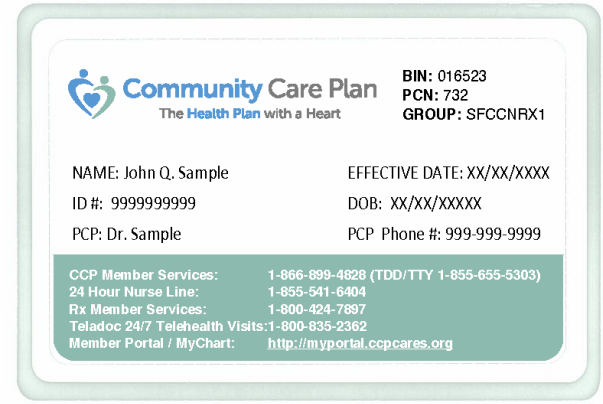
CCP will provide assistance with the coordination of care for the new enrollees.

ENROLLEE ID CARDS

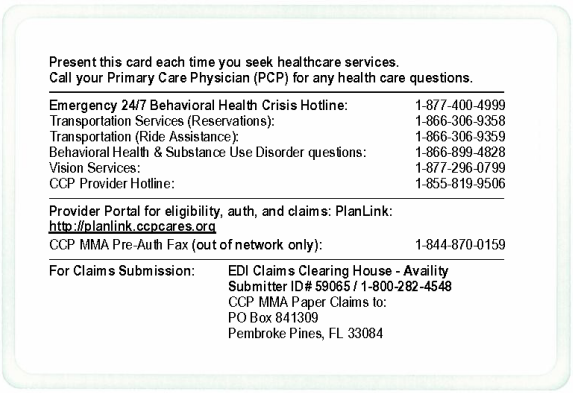
Each CCP enrollee will receive from Medicaid a Medicaid identification card. This card is used to help identify the enrollee and check his/her eligibility in the Florida Medicaid Program. Each CCP enrollee will also receive a CCP identification card which has valuable information on both sides. **Possession of any of these identification cards does not guarantee current Medicaid or PSN eligibility.** The provider **must** verify eligibility by using CCP Provider Web Portal or call Enrollee Services. Enrollees have been asked to carry these cards at all times.

Sample CCP ENROLLEE ID Card

FRONT



BACK



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. If you are the PCP of record, your name will be displayed in the PlanLink provider portal as the member's "CCP- Assigned PCP.". Please contact Member Services for assistance with specific enrollee issues.

PCP RESPONSIBILITIES, PROCEDURES and NEW ENROLLEE PROCESSING

To encourage enrollees to visit their PCP, the CCP Member 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 CCP 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 CCP. When the Health Risk Assessment is received by the CCP 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 CCP Disease Management Program. The original form with valuable information will then be forwarded to the PCP 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, one should be created at this time. In addition to the contact by CCP, PCPs should welcome their new enrollees and request they seek an initial health screening. **Be sure to document any attempts to reach the enrollee in**

the enrollee medical record. 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 childcare centers, eliminating additional work by providers. Additional information can be found on the Florida SHOTS website, www.flshots.com, by phone at (877) 888-SHOT (7468), or by email at flshots@doh.state.fl.us.

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

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

ENGAGING ENROLLEES AND CREATING AN INDIVIDUALIZED TREATMENT PLAN

PCP's have a responsibility to listen to enrollee's health care concerns, including treatment barriers; answer questions; and create an individualized plan of care that engages enrollee participation. When the provider notes failure to keep appointments of follow that plan of care, the provider is responsible for outreach and open discussion with those enrollees to help them understand that these actions may interrupt or even worsen their clinical outcomes. CCP expects providers/provider sites to have a procedure for dealing with such situations. While it is the enrollee's responsibility to keep appointments and to participate 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 the provider concerns and the provider needs to document this activity whether done orally or in writing. Both the CCP 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 and if such a relationship cannot 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 Provider Operations representative. Each case will be evaluated individually to ascertain if a change in PCP is an option. If the enrollee and PCP are not able to negotiate a solution and establish a therapeutic relationship that leads to an effective plan of care, the PCP should notify by certified mail the enrollee and Provider Operations Department of the request to terminate his/her relationship with the enrollee as their 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 CCP Member Services Department at 1-866-899-4828.

SPECIALIST RESPONSIBILITIES

Selected specialty services require a formal referral from the PCP. The specialist may order diagnostic tests without PCP involvement by following CCP's referral guidelines but must abide by the prior authorization requirements. The specialist may not refer to other specialists or admit to the hospital without the approval of CCP, except in a true emergency situation. All non-emergency inpatient admissions require prior authorization from CCP.

COMMUNITY OUTREACH GUIDELINES

CCP's contract with AHCA defines how CCP and its providers advertise the program. CCP requires provider to submit to Provider Operations samples of any community outreach materials intended to distribute to CCP's enrollees for approval from AHCA prior to distribution or display at the office. CCP will submit the materials to AHCA within two (2) business days of receipt and will send Providers written notice of approval or of any changes required by AHCA within two (2) business days of receiving notice from AHCA.

CCP Provider Operations staff will give an overview of the community outreach requirement during provider in-service. It will define what provider may or may not do with regard to reaching out to our enrollees.

Provider Outreach Material Do's and Don'ts:

- May display health plan specific materials in their own office
- May announce new affiliations with a health plan and give their patients a list of health plans with which they contracted
- May co-sponsor events such as health fairs or advertise as a health care provider
- May distribute non-health plan specific information/materials
- Cannot orally or in writing compare benefits or provider network among Health Plans other than to confirm participation in a Health Plan network
- Cannot furnish lists of their Medicaid patient to other Health Plan or entity
- Cannot assist with Health Plan enrollment

BILLING AND PAYMENT FOR SERVICES

PRIMARY CARE PROVIDERS

Primary Care Providers will receive compensation at the agreed upon rate for Medicaid covered services.

SPECIALISTS AND ANCILLARY PROVIDERS

Specialist and ancillary providers will receive compensation at the agreed upon rate for Medicaid covered services.

BILLING PROHIBITIONS

Provider shall accept payment made by CCP, in accordance with the terms and conditions of the "Provider Services Agreement," as payment in full and accept no payment from CCP enrollees, the enrollees' relatives or any other person or persons in charge as the enrollees' 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 CCP or the Agency, insolvency of CCP 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 CCP, acting on the enrollees' 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 CCP when a service has a co-payment as delineated by Medicaid. The co-payments for laboratory and transportation are waived as an expanded benefit. This deduction occurs whether or not the provider collects it from the enrollee. These co-payments do not apply to enrollees under age 21 and pregnant enrollees.

MEDICAID CLAIMS/BILLING TRAINING CLASS

Medicaid offers providers and their office staff Medicaid billing training classes. For more information, please contact CCP Provider Relation Department at 1-855-819-9506.

THIRD-PARTY LIABILITY (TPL) CASES

It is the Provider's responsibility to alert CCP if an enrollee has coverage in addition to CCP enrollment. CCP will then forward this information to the Claims Department for research.

MEDICARE DUAL ELIGIBILITY

CCP enrollees may have both Medicaid and Medicare. Billing and coordination of care should follow the normal dual eligibility requirements and claims rules.

ENCOUNTER DATA

***Providers of capitated services ONLY* -** An encounter is defined by AHCA as an interaction between an enrollee and provider who delivers services or is professionally responsible for services delivered to an enrollee. Encounter data is a record of the services provided. CCP requires the collection and submission of encounter data for all capitated services. CCP providers who furnish capitated services will be required to submit documentation of enrollee encounters to CCP in the applicable HIPAA transaction format. This information will be collected and reviewed by CCP for submission to AHCA. CCP will work with providers of capitated services to ensure that the providers are recognized by the state Medicaid program, including its choice counselor/enrollment broker as participating providers of CCP and that providers' submissions of encounter data are accepted by the data warehouse.

CLAIMS OVERVIEW

BILLING ADDRESS

Providers are responsible for submitting clean, complete, and accurate claims to Community Care Plan in hard copy form or any other approved format to the following address:

COMMUNITY CARE PLAN (CCP)
CLAIMS DEPARTMENT
Availity Payor ID 59065

For information on electronic submission of claims, please contact the CCP Provider Operations Department at 1-855-819-9506.

CLAIMS SUBMISSION

Providers shall submit claims for CCP Managed Services promptly and in accordance with the Florida Medicaid program to CCP. Providers are required to submit all claims within (60) sixty days within date of service. Claims submitted after a six (6) month period from the date of service will automatically be denied by CCP for untimely filing. Claims should be submitted on the red CMS-1500 form, the red UB-04 form or in any other format approved by CCP.

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 Medicaid ID number and appropriate qualifier code (field 17a) or NPI (field 17b)
- Diagnosis codes [ICD-9 ICD-10] (field 21)
- Authorization number (if applicable) * [on UB-04 place in box 63, on CMS-1500 form place in box 23].
- Date of service (field 24a)
- Place of service (field 24b)
- Services rendered [CPT-4, DRG, Revenue code, etc.] (field 24d)
- Diagnosis code Pointer (field 24e; enter diagnosis code reference number in field 21)
- Usual and Customary Charge (field 24f, unshaded area)
- Third-Party Coverage (Fields 24f and 24g shaded area; if payment from a primary insurance carrier is expected or already received, enter the identifier IP for individual policy or GP for group policy and enter the paid or expected amount in the shaded areas of 24f and 24g)
- Units of service (field 24g)

- Child Health Check-up Referral Code or Family Planning Indicator (field 24h; if the service is a child health check-up, enter the referral code that identifies the status of the child: V for patient refused for referral, U for patient not referred, 2 for under treatment and T for new services requested; enter an F if the services relate to a pregnancy or if the services were for family planning; enter an E if the patient was referred for the services as a result of a Child Health Check-up Screening)
- Rendering Provider ID Qualifier (field 24i shaded area) and Medicaid ID number (field 24j; enter a treating provider # if the provider in #33 is a group) or the NPI (unshaded area of 24j; if NPI is mapped to a taxonomy code, enter qualifier ZZ in the shaded field 24i and the taxonomy code in the shaded field 24j).
- 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 (field 33b with Qualifier 1D), billing address, telephone number (field 33) or the NPI number (field 33a and if mapped to a taxonomy code, enter Qualifier Code ZZ and the taxonomy code in field 33b)

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

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

Further details on clean claim submittal can be accessed in the Medicaid Provider Reimbursements handbooks, CMS-1500 or UB-04. All Medicaid handbooks can be found on the EDS website at:
http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx.

CCP compliance with S. 641.3155.F.S., the Prompt Claims Payment statute of the Health Services Program Charter.

CLAIM INQUIRIES

CLAIMS PAYMENT

CCP will pay claims at the agreed rate less any applicable co-payments directly to the provider. Please go to CCP's provider portal, PlanLink to check claim status. If you have other claims inquiries or concerns, please contact CCP via the PlanLink provider portal or at:

COMMUNITY CARE PLAN (CCP)
CLAIMS DEPARTMENT
P.O. Box 841309
Pembroke Pines, FL 33084

866.899.4828

PROVIDER CLAIMS APPEALS

If a Claims denial is received from Community Care Plan (CCP), and you are requesting reconsideration of your claim, you must complete a Provider Claims Appeals Form and mail to:

COMMUNITY CARE PLAN (CCP)
PROVIDER\CLAIMS APPEALS
P.O. Box 841309
Pembroke Pines, FL 33084

Providers may also call CCP's Provider Operations Department at 1-855-819-9506 to file a claims complaint.

PROVIDER CLAIMS DISPUTE ARBITRATION SERVICES VIA AHCA

AHCA is contracted with CAPITOL BRIDGE, an independent dispute resolution organization, to aid health care providers and health plans to resolve claim disputes. CAPITOL BRIDGE has been accepting claim disputes for Florida's managed care line of business since March 11, 2024. Services offered by CAPITOL BRIDGE are available to contracted and noncontracted providers, of Commercial and Medicaid managed care providers and health plans. Claims submitted to managed care plans that have been denied in full or in part, or allegedly underpaid or overpaid may be eligible for dispute under the arbitration process. Application forms and instructions on how to file claims disputes can be obtained directly from CAPITOL BRIDGE by calling 1-800-889-0549 or emailing FLCDR@capitolbridge.com. To learn more about this program, visit the link below.

https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/FAQ.shtml

PROVIDER ADDRESS AND PRACTICE CHANGES

OFFICE CHANGES

It is imperative that you notify your Provider Operations 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

ADDING NEW ASSOCIATES

If a new provider is being added to your practice, please contact your Provider Operations Representative to obtain a provider application. To be a participant in the CCP, the provider must 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 Community Care Plan.

PRIMARY CARE PROVIDER REQUESTING TO CLOSE PANEL

Primary Care Providers need to submit to the CCP 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 REQUSTING TO TERMINATE FROM THE CCP

A CCP provider wishing to terminate his/her agreement with CCP 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 sixty (60) day advance written notice. The provider must continue care in progress during after the termination period for up to six months until a provision is made by CCP for the reassignment of the enrollees. Pregnant enrollees can continue receiving services through postpartum care.

PHARMACY SERVICES

CCP covers prescription drugs when ordered by a CCP doctor. 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. Some medications require prior authorization (PA) or have limitations on age, dosage and/or maximum quantities. 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. CCP needs your active participation in the management of Prescribed Drug Services to CCP enrollees. The CCP Preferred Drug List (PDL) can be accessed at: www.ccpcares.org.

WORKING WITH OUR PHARMACY BENEFIT MANAGER (PBM)

CCP contracts with Magellan Pharmacy Solutions to process all pharmacy claims for prescribed drugs. Certain drugs require PA to be approved for payment by CCP. These include:

- All medications not listed on the CCP Preferred Drug List (PDL)
- Some CCP preferred drugs (designated PA on the PDL)

Magellan Pharmacy Solutions is responsible for administering the prior authorization process for all prescribed drugs requiring PA. Please follow these guidelines for efficient processing of your PA requests:

Prior Authorization Fax:	800-424-7913
Prior Authorization Phone:	800-424-7897
Mailing Address:	Clinical Operations Department Community Care Plan (CCP) C/o Magellan Pharmacy Solutions 11013 West Broad St., Suite 500 Glen Allen, VA 23060

When calling, please have patient information, including Medicaid ID number, complete diagnosis, medical history, and current medications readily available. Upon receipt of all necessary information, Magellan will respond by fax or phone within 24 hours except during weekends and holidays. If the request is approved, information in the on-line pharmacy claims processing system will be changed to allow the specific enrollee to receive this specific drug. If the request is denied, information about the denial will be provided to the prescribe provider.

CCP providers are requested to utilize the PDL when prescribing medication for those patients covered by CCP pharmacy program.

PSYCHOTROPIC MEDICATION PRESCRIBED DRUG SERVICES

In accordance with s. 409.912(51) F.S. effective September 1, 2011, prescriptions for psychotropic medication prescribed for a child under the age of thirteen must be accompanied by the express written and informed consent of the enrollee's parent or legal guardian. Psychotropic (Psychotherapeutic) medications include antipsychotics, antidepressants, anti-anxiety medications, and mood stabilizers. Anticonvulsants and ADHD medications (stimulants and non-stimulants) are not included at this time. The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription. The prescriber must ensure completion of the Medicaid "Informed Consent for Psychotherapeutic Medication" attestation form, the Department of Children and Families CF1630 form; provide the court order for the medication, or an attestation form that includes all elements on the Medicaid attestation form. Every new prescription will require a new informed consent form.

The Medicaid attestation form can be accessed at:
http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml

The DCF CF1630 form can be accessed at:
www.dcf.state.fl.us/dcfforms/Search/DCFFormSearch.aspx

PROVIDER COMPLIANCE

CCP 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. CCP actively, prospectively, and retrospectively analyzes the potential for any occurrence of fraud and abuse and monitors for fraud and abuse using resources such as (but not limited to) claims data, credentialing/re-credentialing, utilization management, quality management, and grievance/appeals. CCP additionally monthly accesses and uses the HHS Office of Inspector General List of Excluded Individuals/Entities and the Federal Excluded Parties List System (EPLS) to identify individuals excluded from participation in Medicaid, and therefore excluded from participation. 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. Provider must comply will all aspects of the CCP fraud and abuse plan/requirements. Provider can access the CCP Compliance Program, Anti-Fraud Plan which include the policy and procedure, and training material at www.ccpcares.org.

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

1. Florida Medicaid Program Integrity Office Fraud and Abuse Hotline: 1-888-419-3456
2. Florida Attorney General's Medicaid Fraud Control Hotline: 1-866-966-7226
3. Department of Health Human Services Office of the Inspector General Federal Hotline: 1-800-447-8477
4. CCP Compliance Hotline: (855) 843-1106

5. Provider can complete the Medicaid Fraud and Abuse Complaint Form and mail the form to:

   Program Administrator, Intake Unit
   Medicaid Program Integrity
   Agency for Health Care Administration
   2727 Mahan Drive, MS #6
   Tallahassee, Florida 32308

   To print a copy of Medicaid Fraud and Abuse Complaint Form, please go to: http://ahca.myflorida.com/Executive/Inspector_General/docs/MedicaidFraudandAbuseComplaintForm.doc

6. Provider can complete the form online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

For additional information regarding Medicaid's Fraud and Abuse policies, provider rights relative to abuse and fraud investigations, provider responsibilities, etc., provider can access the Medicaid General Provider Handbook at:
www.mymedicaid-Florida.com

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statues Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

CULTURAL COMPETENCY

Cultural competency involves awareness and acceptance of all diversity including but not limited to issues surrounding gender identification, race, ethnicity, language, socio-economic concerns, history of trauma, and communication preferences. All providers are expected to be aware of and open to the cultural backgrounds and concerns of the patients they serve and to be sensitive toward issues of cultural diversity and their effects on health literacy. Providers should post clear, multilingual signs in the reception area about the availability of linguistic services and services for the hearing impaired. Providers should also make certain the information used for health education reflects the cultural background and the literacy of their population and reflects diversity in how they are presented. Staff training should include information about all aspects of cultural diversity, the importance of non-verbal communication in patient care, soliciting patient concerns, and identifying and addressing patients with health literacy issues. Providers need to ask each patient about their language preference and include the information in their medical record. CCP requires all providers to be trained on the CCP Cultural Competency Plan. The plan includes a description of how providers can effectively provide 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.

Providers can access the full CCP Cultural Competency Plan at www.ccpcares.org or by calling Provider Services.

ABUSE, NEGLECT AND EXPLOITATION

Suspected cases of abuse, neglect and/or exploitation must be reported to the Florida Department of Children and Families. The Florida Abuse Hotline number is 1-800-962-2873. The Florida Department of Children and Families is responsible to investigate allegations of abuse and neglect. In addition, CCP requires that all staff and providers to report the adverse incidents to the CCP Risk Manager within twenty-four (24) hours of the incident. (See CCP Adverse Incident Form on page 56) Reporting will include information: Enrollee's identity, description of the incident and outcomes including current status of the Enrollee. If the event involves a health and safety issue, CCP case manager will assist to relocate the Enrollee from his/her current location to accommodate a safe environment. Documentation related to the suspected abuse, neglect, or exploitation, including the reporting of such, must be kept in a file, separate from the Enrollee's case file, that is designated as confidential.

PROVIDER ACCESS AND AVAILABILITY

Providers are expected to provide care to Enrollee's in a timely manner. Enrollee's value timely access to medical care. Community Care Plan monitors primary care appointment and after-hours access and specialty care and behavioral health practitioner appointment accessibility annually against its standards, and initiates actions as needed to improve. Please see the results of the annual Provider Survey conducted by Community Care Plan related to access and availability.

TIMELY ACCESS REQUIREMENT

Quarterly Community Care Plan measures primary care and specialty care appointment access through a survey of physician offices. The providers are selected by using a statistical valid sample or by surveying all providers offices for the required specialties. Offices for each practitioner specialty are surveyed separately. Community Care Plan surveys high volume and high impact specialties (Oncology and Ob/Gyn) along with Primary Care Physicians (Internal Medicine, Family Practice, and Pediatrics). All offices are included in data collection. Data is collected by phone survey administered internally or by fax survey.

The process is as follows:

1. The survey questions are asked once for each office, and data is recorded for the open appointments, regardless of the practitioner who has open appointments, if there are multiple providers in the office.
2. For routine appointments, data is gathered on first, second and third available appointments.
3. Routine appointment standard is based on the date of the third available appointment because it is the most sensitive method for detecting offices which have access issues since first and second available appointments often represent cancellations. Although those open appointment slots frequently are available in a timely fashion, they often do not work for members.
4. Urgent appointment data is gathered for the first available urgent appointment slot in the office. Because many offices have different practices for scheduling new patients versus established patients, data is collected separately for those two patient groups.
5. Providers receive notification in writing on the results of the survey. They are notified if they have passed or failed.
6. The medical practices that fail are re-surveyed within thirty (30) days. They receive notification of the re-survey results. If they fail the re-survey results, the provider is reported to the Quality Improvement Committee for approval of a corrective action plan. Prior to presenting to the Quality Improvement Committee, Provider Operations Management meets with the office to discuss the contract guidelines.
7. Provider Operations meet with these providers, the contractual obligation is discussed, and the discussion includes how to comply as soon as possible. If the contract requirement is not met, this may result in a provider termination if deemed acceptable by the Quality Improvement Committee.
8. Providers are advised that non-compliance may result in the termination of the provider contract. The Medical Management team, Credentialing department and Member Services department, as well as all other impacted departmental areas, are notified of the provider termination.

Provider Operations conducts ad-hoc surveys if a pattern or trend is noted for a provider office or specialty based on complaints received from members or providers. This is part of the overall provider monitoring that occurs via an inter-departmental collaboration.

CCP's performance goal for appointment availability is that 95% of surveyed providers follow AHCA standards, regarding primary care and specialist's provider wait times. Report is compiled and completed quarterly in compliance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. (42 CFR 438.206(c)(1)(iv), (v), and (vi)). Providers are surveyed on a quarterly basis to be following reporting results on a quarterly basis.

ACCESS GUIDELINES

Urgent medical/behavioral health care services Appointments shall be as follows:

(a) Request for services not requiring pre-authorization - within two (2) days of request
(b) Request for services requiring pre-authorization - within four (4) days of a request

Non-urgent care services shall be provided as follows:

(a) (a)Requests for post-discharge from an inpatient behavioral health facility - within seven (7) days
(b) (b)Requests for initial outpatient behavioral health services - within fourteen (14) days
(c) Requests for ancillary services related to the treatment of injury, illness, or other medical condition – within fourteen (14) days
(d) Requests for Primary care appointment - within thirty (30) days
(e) Request for a specialist appointment - within sixty (60) days

GEOGRAPHIC ACCESS AND RESULTS

Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Primary Care Practitioners: Family and general practitioners	99% of enrollees have at least 1 FP/GP within 5miles At least 1 FP/GP per 1500 enrollees	GeoAccess Ratio of FP/GP per enrollees	Annually Annually
Primary Care Practitioners: Internal Medicine	99% of adult enrollees have at least 1 IM within 5 miles At least 1 IM per 1500 adult enrollees	GeoAccess Ratio of IM per enrollees	Annually Annually
Primary Care Practitioners: Pediatrics	99 % of enrollees under age 18 have at least 1 pediatrician within 5 miles At least 1 pediatrician per 1500 enrollees under age 18	GeoAccess Ratio of Peds per enrollees	Annually Annually
High volume specialty: Obstetrics and gynecology	95% of enrollees have at least 1 OB/gyn within 20 miles At least 1 Ob/Gyn per 1500 enrollee	GeoAccess Ratio of Ob/Gyn per enrollees	Annually Annually

Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
High impact specialty: Oncology	95% of enrollees have at least 1 Oncology within 20 miles At least 1 Ob/Gyn per 5,200 enrollees	GeoAccess Ratio of Oncology per enrollees	Annually Annually

MEASUREMENT RESULTS AND COMPARISON TO PERFORMANCE GOAL BY PRACTITIONER TYPE

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
Primary Care Practitioners: Family and General practitioners	95% of enrollees have at least 1 FP/GP within 5 miles At least 1 FP/GP per 1500 enrollees.	99.9% of enrollees have at least 1 FP or GP within 5 miles 1 FP/GP per 184 enrollees.	Yes Yes
Primary Care Practitioners: Internal Medicine	95% of adult enrollees have at least 1 IM within 5 miles At least 1 IM per 1500 adult enrollee	99% of enrollees have at least 1 FP or GP within 5 miles 1 IME per 233 enrollees.	Yes Yes
Primary Care Practitioners: Pediatrics	95% of enrollees under age 18 have at least 1 pediatrician within 5 miles At least 1 Pediatrician per 1500 enrollee under age 18	99.9% of enrollees have at least 1 FP or Ped within 5 miles 1 Ped per 86 enrollees.	Yes Yes
Obstetrics and gynecology	95% of enrollees have at least 1 Ob/Gyn within 20 miles At least 1 Ob/Gyn per 1500 enrollee	98% of enrollees have at least 1 Ob/Gyn within 20 miles 1 Ob/Gyn per 273 enrollees	Yes Yes
Oncology	95% of enrollees have at least 1 Oncology within 20 miles At least 1 Ob/Gyn per 5,200 enrollees	100% of enrollees have at least 1 Oncologist within 20 miles 1 Oncologist per 972 enrollees	Yes Yes

APPOINTMENT ACCESS STANDARDS AND RESULTS

Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care routine appointments	Results of members who report they always or usually obtained routine appointments as soon as they needed it meets Adult (75th) Quality Compass percentile and Pediatric (75th) Quality Compass percentile.	CAHPS member satisfaction survey	Annually
Primary care urgent appointments	Results of members report they always or usually obtained urgent care as soon as they needed it meets [40th] Adult Quality Compass percentile and Pediatric (42nd) Quality Compass percentile.	CAHPS member satisfaction survey	Annually
Primary care after hours care	100% of PCP offices have an after-hours access mechanism that meets health plan standards.	Calls to PCP offices after hours	Annually
Access complaint analysis	Rate of member complaints about physical health appointment access equals 0 per 1000 members	Complaint analysis	Annually
Member appeals related to access analysis	Rate of member appeals about physical health access equals 0 per 1000 members	Appeal analysis	Annually

Measurement Results and Comparison to Performance Goal by Appointment Type and Product Line

Access Measure	Standard	Results	Goal Met? (Yes/No)
Primary care routine appointments	Results of members report they always or usually obtained regular or routine care as soon as they needed it meets Adult (75th) Quality Compass percentile and Pediatric (75th) Quality Compass percentile.	Medicaid Adult Routine 84.93%, 94th percentile Medicaid Pediatric Routine 90.06%, 72nd percentile	Yes, for Medicaid Adult, No for Medicaid Pediatric
Primary care urgent appointments	Results of members report they always or usually obtained regular or routine care as soon as they needed it meets Adult (75th) Quality Compass percentile and Pediatric (75th) Quality Compass percentile.	Medicaid Adult Routine 82.86%, 48th percentile Medicaid Pediatric Routine 90.43%, 22nd percentile	No for Medicaid Adult, No for Medicaid Pediatric
Primary care after hours care	75% of PCP offices have an after- hours access mechanism that meets health plan standards	74% of office have after-hours access	Yes
Access complaint analysis	Rate of member complaints about physical health appointment access less than 5 per 1000 members	No complaints for access	Yes
Member appeals related to access analysis	Rate of member appeals about physical health access less than 3 per 1000 members	No complaints for access	Yes

Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
OB/GYN new patient routine appointments	75% of offices report a third available routine appointment is open for a new patient within 30 days of patient request	Office appointment access survey	Annually
OB/GYN established patient routine appointment	75% of offices report a third available routine appointment is open for an established patient within 30 days of patient request	Office appointment access survey	Annually
OB/GYN new patient urgent appointment	75% of offices report the first available urgent appointment is open for a new patient within 1 day of patient request	Office appointment access survey	Annually
OB/GYN established patient urgent appointment	75% of offices report the first available urgent appointment is open for an established patient within 1 day of patient request	Office appointment access survey	Annually
Oncology new patient routine appointments	75% of offices report a third available routine appointment is open for a new patient within 30 days of patient request	Office appointment access survey	Annually
Oncology established patient routine appointment	75% of offices report a third available routine appointment is open for an established patient within 30 days of patient request	Office appointment access survey	Annually
Oncology new patient urgent appointment	75% of offices report the first available urgent appointment is open for a new patient within 1 day of patient request	Office appointment access survey	Annually
Oncology established patient urgent appointment	75% of offices report the first available urgent appointment is open for an established patient within 1 day of patient request	Office appointment access survey	Annually
Complaints	Rate of member complaints about appointment access is less than 5 per 1000 members	Complaint analysis	Annually

Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Appeals	Rate of member appeals about physical health access is less than 3 per 1000 members	Appeal analysis	Annually
Specialty care appointment access	Results of members who report they always or usually obtained a specialist appointment as soon as they needed it meets 75th Quality Compass percentile for Adult and for Pediatric	CAHPS survey	Annually

Response Rate Data

Practitioner Type	# Office locations w/Practitioner type	# & % Office locations responding to survey	# Practitioners represented by offices responding to survey	# Practitioners of this type in the Network	% of Practitioner type results represent out of total contracted practitioners of that type
OB/GYN	38 offices/41 Ob/Gyn	38 offices, 100%	41	41	100%
Oncology	11 offices/13 Oncologist	11 offices, 100%	13	13	100%

MEASUREMENT RESULTS AND COMPARISON TO PERFORMANCE GOAL BY ACCESS MEASURE

Measurement Results and Comparison to Performance Goal by Access Measure

Access Measure	Standard	Results	Goal Met? (Yes/No)
OB/GYN new patient routine appointments	75% of offices report a third available routine appointment is open for a new patient within 30days of patient request	85% of offices report a third available routine appointment is open for a new patient within 30 days of patient request	Yes
OB/GYN established patient routine appointment	75% of offices report a third available routine appointment is open for an established patient within 30 days of patient request	85% of offices report a third available routine appointment is open for an established patient within 30 days of patient request	Yes
OB/GYN new patient urgent appointment	75% of offices report the first available urgent appointment is open for a new patient within1 1 days of patient request	76% of offices report the first available urgent appointment is open for a new patient within 1 day of patient request	Yes
OB/GYN established patient urgent appointment	75% of offices report the first available urgent appointment is open for an established patient within 1 days of patient request	76% of offices report the first available urgent appointment is open for a new patient within 1 day of patient request	Yes
Oncology new patient routine appointments	75% of offices report a third available routine appointment is open for a new patient within 30 days of patient request	100% of offices report a third available routine appointment is open for a new patient within 30 days of patient request	Yes
Oncology established patient routine appointment	75% of offices report a third available routine appointment is open for an established patient within 30 days of patient request	100% of offices report a third available routine appointment is open for an established patient within 30 days of patient request	Yes
Oncology new patient urgent appointment	75% of offices report the first available urgent appointment is open for a new patient within1 1 day of patient request	69% of offices report the first available urgent appointment is open for a new patient within 1 day of patient request	No
Oncology established patient urgent appointment	75% of offices report the first available urgent appointment is open for an established patient within 1 day of patient request	69% of offices report the first available urgent appointment is open for an established patient within 1 day of patient request	No
Complaints	Rate of member complaints about appointment access is less than 5 per 1000 members	No complaints for access.	Yes

Measurement Results and Comparison to Performance Goal by Access Measure

Access Measure	Standard	Results	Goal Met? (Yes/No)
Appeals	Rate of member appeals about physical health access is less than 3 per 1000 members	No access appeals.	Yes
Specialty Care Appointment Access	Results of members who report they always or usually obtained a specialist appointment as soon as they needed it meets 75th Quality Compass percentile for Adult and Pediatric.	Adult results = 84.21% met Quality Compass 90th Percentile. Pediatric results = 67.28 % met Quality Compass 5th Percentile	Yes, for Adult results No, for Pediatric results

ENROLLEE INFORMATION

ENROLLEE SERVICES

The primary responsibility of the Member Services Department is to facilitate and guide enrollees in accessing health care services and information about Community Care Plan. 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 CCP 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
- Receive and process primary care provider assignment and transfer requests

PRIMARY CARE PROVIDER ASSIGNMENT

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

When enrolling with CCP, each enrollee will either choose a Primary Care Provider or be assigned one 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 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

Community Care Plan (CCP) 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 CCP Member Services Department at 1-866-899-4828. Transfer requests may be initiated by the enrollee or the enrollee's legal guardian. The enrollee will receive a new CCP ID Card from Member Services indicating the new PCP name.

QUALITY ENHANCEMENTS

CCP maintains information regarding programs and resources in the community known as Quality Enhancements (QEs). The QE program can include, but is not limited to the following:

- Children's Programs
- Domestic Violence
- Pregnancy Prevention
- Smoking Cessation
- Substance Abuse

Information regarding these programs is included in the new provider packet. Providers can also call CCP for additional information.

HEALTHY BEHAVIOR PROGRAMS

CCP offers three (3) healthy behaviors programs to our enrollees. These programs are:

- Smoking cessation
- Weight loss (*Enrollee with a BMI ≥ 40)*
- Substance abuse recovery program

Our smoking cessation program is offered though AHEC/Nova Southeastern University and Tobacco Free Florida. Class sessions are weekly for four (4) to six (6) weeks and are available at various times and locations throughout Broward and North Dade counties, as well as virtually. Nicotine replacement therapy is provided free of charge as part of this program. Enrollees who complete all sessions are provided a gift card incentive for graduating from this program.

For our enrollees with a BMI of 40 or more, CCP provides three (3) visits to a participating nutritionist at no cost to the enrollee. To ensure that any weight loss program is medically supervised, the member will have 2 visits with their Primary Care Provider to monitor health and progress. The member is provided a gift card incentive upon successful completion of all visits.

For our enrollees with a substance use disorder, Community Care Plan offers an individualized substance use recovery program. Members are assigned to a CCP Care Manager who will coordinate services to participating substance use treatment programs and monitor adherence to their plan of care in conjunction with the member's provider. Upon successful completion of the program, members who remain sober are eligible for an incentive.

For more information on any of these programs or to obtain referral forms, please call us at 1-866-899-4828.

The Healthy Behavior Program also includes rewards for members who get routine wellness visits annually. These include Pregnancy, Adult, Child, and Diabetic wellness visits. For more information go to **www.ccpccares.org** or call 1-866-899-4828.

For more information on any of these programs or to obtain referral forms, please call us at 1-866-899-4828.

ENROLLEE RIGHTS AND RESPONSIBILITIES

Providers are responsible for facilitating the following enrollee rights and responsibilities. Community Care Plan strives to foster enrollee satisfaction, respect, and availability of information through open communications. We, therefore, have written the following Enrollee Rights and Responsibilities which must be respected and facilitated by our network providers. Certain rights are provided for by law (42 CFR 438.100; 42 CFR 438.102; 45 CFR 164.524 and 45 CFR 164.526).

Enrollee Rights:

- To be treated with respect and with due consideration for dignity and privacy.
- To obtain information on available treatment options and alternatives regardless of cost, benefit coverage or condition, presented in a manner that is understood.
- To be given the opportunity to participate in decisions involving care, including the right to refuse treatment.
- To get the care and services covered by Medicaid.
- To get good medical care regardless of race, origin, religion, age, disability, or illness.
- To ask for and get a copy of medical records. To request medical records be changed or amended. Changes can only occur as allowed by law.
- To get a second opinion from another doctor.
- To get service from out-of-network providers.
- To participate in experimental research.
- To change providers at any time. Members can ask for another primary care doctor (PCP) or specialist.
- To file a complaint, grievance or appeal through the plans grievance and appeals process about the services provided by the plan or one of the plan's providers.
- To not be restrained or secluded or made to act a certain way or get back at them.
- To obtain oral interpretation services free of charge and information on how to access those services.
- To get information about Advanced Directives, if over 18.
- To exercise rights and not have it affect the way they are treated.
- To make suggestions regarding the plans Members Rights and Responsibilities policy.
- To get information from CCP in the format or language they need. Information like:
    - ❖ How we approve services (authorization/referral process, medical necessity);
    - ❖ How we make sure we keep getting better at what we do (Quality Improvement Program);
    - ❖ How we measure the quality of our services (Performance Measures);
    - ❖ The plans participating provider and facility list;
    - ❖ The prescription drugs covered by CCP;
    - ❖ How we keep your information confidential;
    - ❖ How we run the program. How we operate. Our policies and procedures; and
    - ❖ If we have any provider incentive plans.
    - ❖ How to access Member Rights and Responsibilities.

Enrollee Responsibilities:

- To call the PCP before getting care unless it is an emergency. To call the PCP when sick and need care.
- To listen and work with the providers.
- To give the providers the appropriate medical information they need for their care.
- To talk to the doctor if they have questions or concerns.
- To follow the treatment plan recommended and that they have agreed to by their provider.
- To ask questions to providers to determine the potential risks, benefits, and costs of treatment alternatives, and then making care decisions after carefully weighing all options.
- To notify their provider of the reasons why they cannot the follow the recommended treatment plan.
- To carry the ID card at all times.
- To call the provider if they cannot make it to an appointment.
- To call DCF if their address or telephone number changes.
- To tell us or Medicaid if they suspect fraud.

CCP will not impose enrollment fees, premium, or similar charges on Indians served by an Indian health care provider, Indian Health Services, an Indian Tribe, Tribal Organization, or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

PROVIDER ASSISTANCE WITH ENROLLEE GRIEVANCES AND APPEALS

The right to file a grievance or appeal belongs to the Enrollee. However, CCP recognizes that there are times the enrollee wants assistance from their provider to act on these rights. The following section explains that process.

GRIEVANCE/APPEAL DEPARTMENT
Office Hours: 8:00 a.m. – 5:00 p.m.
Phone: 1-866-899-4828 (Ask for Grievance/Appeal Coordinator)

Community Care Plan (CCP)
1643 Harrison Parkway, Building H, Suite 200
Sunrise, Florida 33323

If an enrollee is not satisfied with a service or provider and would like to file a complaint or grievance, he or she may do so by calling the CCP Member Services Department at 1-866-899-4828 or may submit a grievance by using a CCP grievance form or submit a detail letter. A copy of the form is attached (see page 41) and it can be duplicated for enrollee use. The following outlines the procedure. A complaint becomes a grievance after 24 hours if not resolved.

ENROLLEE GRIEVANCES

If an enrollee is dissatisfied with services provided by CCP, you or the enrollee can call the CCP Member Services Department at 1-866-899-4828 to request assistance.

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

Community Care Plan
Attention: Grievance & Appeal Coordinator
1643 Harrison Parkway, Building H, Suite 200
Sunrise, Florida 33323

We will send the enrollee a letter approximately five (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 90 days.

ENROLLEE APPEALS (INLCLUDING MediKids)

If the enrollee receives an Adverse Benefit Determination Letter, 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 CCP 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 within 10 days. You must have the enrollee's permission in writing to appeal on their behalf. The appeal letter must be sent within 60 days from the date of our action letter to:

Community Care Plan
Attention: Grievance & Appeal Coordinator
1643 Harrison Parkway, Building H, Suite 200
Sunrise, Florida 33323

Tel: 1-866-899-4828

We will review the appeal and tell the enrollee what we found no later than 30 days after we receive the request. If the appeal was in writing only, the 30 days starts from the day we receive the written appeal. If the appeal was by phone and then by letter, the 30 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. 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.

The enrollee can must complete CCP's appeal process before asking for a Medicaid Fair Hearing. The enrollee has up to 120 days after the notice of plan appeal determination to request a Medicaid Fair Hearing. The enrollee may request the hearing by calling or writing to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

Tel: 1-877-254-1055, Fax: 1-239-338-2642

MedicaidHearingUnit@ahca.myflorida.com

At this hearing, you can also represent the enrollee with the enrollee's written permission.

If CCP continues or restarts the enrollee's benefits while waiting for an Appeal Decision, 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 continuation of services.
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. The criteria for an expedited appeal is that waiting for standard appeal resolution (within 30 days) could seriously jeopardize the enrollee's life, health, or ability to obtain, maintain or regain maximum function. 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 48 hours. We will try to call you and the enrollee about the results right away. We will also mail the enrollee a letter within two (2) working days.

The letter of appeal should be sent to CCP:

Community Care Plan
Attention: Grievance & Appeal Coordinator
1643 Harrison Parkway, Building H, Ste. 200
Sunrise, FL 33323

Tel: 1-866-899-4828

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

ENROLLEE GRIEVANCE FORM

ENROLLEE'S NAME:	DATE:
ENROLLEE'S MEDICAID #:	ENROLLE'S PHONE:
ENROLLEE'S ADDRESS:	
PROVIDER NAME:	PROVIDER MEDICAID #:
DESCRIPTION OF GRIEVANCE:	

--FOR CCP 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: CCP 1643 Harrison Parkway, Building H, #200, Sunrise, FL 33323

FORM ADM-2

UTILIZATION MANAGEMENT

REFERRAL PROCEDURES

Prior authorization requires the provider or practitioner to make a formal medical necessity determination request to the plan prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for only those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review. CCP's Medical Management Department reviews the Prior Authorization List regularly to determine if any services should be added or removed from the list. Such decisions are made in collaboration with the Provider Services Department. Providers are notified forty-five (45) days prior to any changes occur.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. All participating providers must use the provider portal, PlanLink, to request prior authorization of elective and scheduled services. The timeframes below comply with AHCA Requirements for decision making. Turnaround times for authorization of requested services are as follows:

- Expedited requests will not exceed 2 business days.
- Standard requests will not exceed 7 calendar days.
- Retrospective / Post Service requests will not exceed 30 calendar days.

CCP has adopted utilization review criteria specific to the services provided which include:

- Change Healthcare InterQual® level of care criteria. InterQual® is utilized as a screening guide and is not intended to be a substitute for practitioner judgment.
- As contractually indicated CCP will utilize the Florida Medicaid Coverage and Limitations Handbooks to evaluate requests for medical appropriateness / necessity.

American Society of Addiction Medicine (ASAM)Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used for the approval of medical necessity but not for the denial of services. All potential denials of medical necessity are reviewed by the Medical Director.

When an enrollee or practitioner/provider call is received by the CCP Member Services Department regarding the UM process and authorization of care, the Member Services representative will triage the call and warm transfer the call to an UM nurse as needed. When addressing these calls, the UM staff will identify themselves by name, title, and organization name. This interaction will be documented in Tapestry via a Customer Relationship Management (CRM) record.

Physicians can request a copy of Utilization Management criteria by contacting Member Services 866-899-4828.

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® and other nationally recognized criteria and Medicaid Coverage and Limitations are still not met, the request will be forwarded to the Medical Director for review and determination. Practitioners have the opportunity to discuss any medical or behavioral UM denial decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination.

Authorization will be required for all items listed on the SERVICES REQUIRING PRIOR AUTHORIZATION listing. (See page 57)

Providers may request authorization for medically necessary services to enrollees under the age of twenty-one (21) years when the service is not listed in the covered service in this manual or in the Florida Medicaid Coverage and Limitation Handbook, Florida Medicaid Coverage Policy or in the Medicaid Fee Schedule or if the service requested exceeds the amount, frequency, or duration of the published limitation. Provider

Any services on the authorization list, which are rendered/performed without an authorization from the health plan, will be denied for lack of authorization. Authorization numbers will be assigned by CCP.

CCP, the health plan with a heart, wants you to know these important facts:

- Decision making at CCP is based ONLY on appropriateness of care and service, and existence of coverage.
- Community Care Plan does not reward practitioners, or other individuals for issuing denials of coverage.
- At CCP our decisions are not connected to any financial incentive. Our staff is not encouraged to make decisions that result in underutilization.

PLEASE REFER TO THE ATTACHED LIST OF SERVICES THAT REQUIRE PRIOR AUTHORIZATION. AUTHORIZATIONS ARE VALID UP TO 60 DAYS UNLESS OTHERWISE INDICATED AT THE TIME AUTHORIZATION IS ISSUED.

SERVICES REQUIRING AUTHORIZATION

Prior Authorization is required for all Out-of-Network Services. Visit the link below to CCP's website to view the most current MMA prior authorization list. Please submit supporting clinical documentation with your request so that we can determine medical necessity.

https://ccpcares.org/Providers/MMA/ServicesRequiringPriorAuthorization

PRIOR AUTHORIZATION FOR NEW ENROLLEES TO CCP

Enrollees become effective in CCP either via a voluntary process (the individual elects the CCP) 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 for up to sixty (60) days after the effective date of enrollment in CCP or until CCP's PCP reviews the enrollee's treatment plan, whichever comes first. Services need to have been pre-arranged prior to enrollment in CCP. These services include:

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

CCP will 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 CCP 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 CCP at the time of notification and determination of medical necessity.

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

SCOPE OF SERVICE
Emergency services will be provided to all enrollees in accordance with State and Federal laws. Community Care Plan (CCP) 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 CCP's Utilization Management Department is notified of the emergency room visit, the PCP will be notified as well via fax or telephone by CCP 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. 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 on 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 the Medicaid Hospital Coverage and Limitations Handbook.

Reimbursement for outpatient hospital services is limited to $1,500.00 per Medicaid fiscal year for recipients 21 years of age and older. There are no dollar limitations for recipients under the age of 21.

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

CCP 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-04 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 Coastal either by the provider's office or the designated accepted entity as per CCP. Coastal's Provider Services line is 833-204-4535.

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 CCP'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 CCP 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 CCP 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 CCP'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 Coastal. A plan of care or clinical documentation supporting medical necessity / appropriateness should be submitted along with the Pre-authorization/Referral form.

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

LABORATORY SERVICES

Providers may utilize the CCP contracted laboratory for CCP enrollees. Outpatient lab services should be used when possible to preserve the maximum benefit for adults.

PLEASE REFER TO THE LIST PROVIDED BY CCP FOR CONTRACTED LABORATORY.

BEHAVIORAL HEALTH SERVICES

Behavioral Health Services, both inpatient and outpatient, are managed by Community Care Plan. Behavioral Health Services must be provided by a provider contracted with Community Care Plan. To obtain assistance in making a referral call Community Care Plan at 1-866-899-4828. Community Care Plan will monitor use of emergency rooms and re-admission rates for Behavioral Health Services.

It is the responsibility of Community Care Plan 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 Community Care Plan Network provider. 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 and/or parent(s)/guardian(s) of minor 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.

For non-life-threatening behavioral health emergencies, CCP directs practitioners to refer the members to the emergency department.

ENROLLEE SELF REFERRAL

Enrollees may self-refer *without authorization* to contracted, in-network providers. Directly accessed providers are required to submit claims to CCP for processing.

OUT-OF-SERVICE-AREA MEDICAL NEEDS

Out-of-Service-Area procedures/services must be pre-certified and deemed medically necessary by the Utilization Management Department. At the time of the referral to the Utilization Management Department, the supporting documentation must accompany the referral request. All Out-of-Service-Area requests for service will be reviewed and determinations on delivery of care will be made by the Medical Director. 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 CCP providers are responsible for following. These handbooks may be accessed online at http://mymedicaid-florida.com [then to Public Information for Providers, then to Provider Support, then to Provider Handbooks] or they can be purchased from the Medicaid fiscal agent, EDS. These handbooks include immunization schedules, footnotes and applicable forms required by Medicaid.

Provider Support lines and resources currently available for Medicaid remain available to you through the Medicaid fiscal agent, and the Agency for Health Care Administration. In the CCP Program, all Florida Medicaid handbooks and other benefits and limitations are applicable.

TELEMEDICINE COVERAGE PROVISIONS

CCP utilize telemedicine for covered services, as follows:

- Telemedicine services provided under Florida Medicaid must be performed by licensed practitioners within their scope of practice
- Telemedicine services must involve the use of interactive telecommunications equipment which includes, at a minimum, audio and video equipment permitting two-way, real-time, communication between the enrollee and the practitioner; and
- Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.
- When providing services through telemedicine, the following must occur:
- The telecommunication equipment and telemedicine operations meet the technical safeguards required, where applicable
- CCP's providers using telemedicine comply with HIPAA and other state and federal laws pertaining to patient privacy
- CCP's telemedicine policies and procedures comply with the requirements in this Contract; and
- Provider training regarding the telemedicine requirements in this Contract.

When telemedicine services are provided, the enrollee's medical/case record includes documentation, as applicable.

(a) Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services. The enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter.

(b) CCP's nor its subcontractor(s) do not reimburse the provider(s) for the costs or fees of any of the equipment necessary to provide services through telemedicine, including:

i. Telephone conversations, chart reviews, electronic mail messages, or facsimile transmissions
ii. Equipment required to provide telemedicine services

CCP includes procedures specific to prevention and detection of potential or suspected fraud and abuse of telemedicine in its fraud and abuse detection activities. Please contact the Provider Operations Hotline for more information on requirements to provide this service.

MEDICAID WAIVER PROGRAMS

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

CCP does not manage these services. You may contact the local Area Medicaid Office for additional information if you believe a CCP enrollee may benefit from any of the programs.

Providers are requested to notify CCP Case Management 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.

CASE MANAGEMENT

PROGRAM OVERVIEW

The philosophy of CCP's Case Management (CM) Program was adopted from the Case Management Society of America's definition. "Case management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes." Case Management is a collaborative process. Nurses and other licensed healthcare professionals who staff CCP's CM programs will assist PCPs by facilitating the case management process. Collaborative CM ultimately leads to COC and quality care for CCP members.

Case Management consists of seven processes:

1. Member Identification
2. Comprehensive Case Assessment
3. Individualized Care Plan Development/Update
4. Care Plan Implementation/Interventions
5. Care Plan Monitoring and Evaluation
6. Case Discharge
7. Evaluation/Outcomes

CCP's overall goal of case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves a comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring, and follow-up.

In accordance with NCQA standards, CCP considers case management to be an opt-out program; all eligible members have the right to participate or to decline.

CCP offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in other CCP DM or care coordination programs.

CCP's CM Program identified the following goals and objectives which will ultimately assist members and families to receive quality and cost-effective services that will positively impact member/family, community, and organizational outcomes:

- Members will be able to obtain access to quality care and appropriate services through coordination of care of their health care needs.
- Concierge Care Coordination (C3) Nurse Managers will provide support and education to the members/caregivers to help them reach their maximum achievable health potential and independence

- The member/caregiver will be self-empowered to know what steps to take if their medical condition changes.
- Proactively identification of members who have multiple or complex medical and/or psychosocial needs or who are at risk of developing complex needs during an acute episode of illness
- Provide early intervention for members appropriate for CM to prevent a recurrent crisis or unnecessary hospitalizations
- Support and reinforce providers recommended treatments and therapies
- Strengthen members/caregiver's interactions with their health care providers
- Serve as a liaison to community resources regarding options and services not covered by the benefit plan
- Assist members/caregivers to better understand their individual health care benefits
- Support members/caregivers individualized learning needs related to their health management
- Improve the quality of life, functional status, and overall health
- Facilitate communication among the member, caregiver, health care providers, community resources/agencies and the health plan to enhance cooperation while planning for and meeting the health care needs of the member
- Increase member/caregiver and provider satisfaction through the collaboration, coordination, and management of health care resources
- Function as an educator for members, the healthcare team and the community regarding the CM process and specific healthcare issues
- Serve as an advocate for the member, family, and caregiver
- Partner with providers, care management team, members/caregivers, and the community in assisting the member/caregiver to reach maximum achievable medical potential and maximum independence

CONCIERGE CARE COORDINATION (C3) MODEL

CCP outlines the collaborative nature of care coordination across the continuum within that managed care system, based on our C3 Model.

The C3 Model ensures a holistic approach in which CCP members receive care across the continuum utilizing a dedicated C3 Nurse Manager and the support of the C3 Team members that includes a representative from each CCP department.

The mission of CCP's C3 Program is to:

- Improve the quality of care to CCP's members within a managed care system of delivery
- Provide excellent concierge care services
- Positively Impact the health and wellness of our community
- Deliver the right care, at the right time, in the right place, in an efficient, cost-effective manner.

This program was created to promote quality of care and cost-effective outcomes by strategically aligning C3 team members' roles and responsibilities targeted to provide the necessary planning, implementation, coordination, evaluation, and monitoring required to meet the CCP member's health needs as well as support effective case management and preventative care practices for our providers.

C3 is a collaborative process driven by the implementation of appropriate courses of care based on clinical, evidence-based practice guidelines. The process features proactive, individualized coordination and creation of an appropriate cost-effective alternative for members, including:

- CASE MANAGEMENT, for catastrophic and chronically ill/injured members, including medically complex and fragile members
- DISEASE MANAGEMENT, for those with appropriate diagnoses that require ongoing education and closing disease and preventative care gaps
- CARE COORDINATION for all members to close preventative gaps in care

The C3 Model ensures a comprehensive and holistic approach to individualized preventative care in which the member and caregiver are involved and receive the support of the entire C3 Team.

CCP's C3 Model provides the necessary planning, implementation, coordination, evaluation, and monitoring required to meet the member's health needs. The care coordination process promotes quality of care and cost-effective outcomes by strategically aligning the C3 team members' roles and responsibilities.

The C3 team consists of a *C3 Nurse Manager*, a Medical Director, the Clinical Pharmacist, a Social Worker, the member's Primary Care Physician, the Provider Operations Department, and the Behavioral Health nurse, Quality Management, Customer Service and UM. The members of this team coordinate all their resources and efforts in order to succeed in meeting the member's health needs and therefore improves their quality of life.

To refer members for CM services, please call 1-866-930-0944.

HEALTH RISK ASSESSMENT (HRA)

Every month, CCP mails a Welcome Packet to all new members who join CCP. Included in the packet is an HRA, for the member to complete and return directly to the CCP Customer Services (CS) Department in the postage-paid, self-addressed envelope provided.

CCP CS Representatives will screen the assessments to identify members who require CM services or who could benefit from a CCP DM program. In addition, individuals with special health needs and related care coordination needs will be identified. The CS Rep will complete the appropriate referrals to initiate case or disease management for the member. The Case Manager or Disease Manager assigned to the member's case will contact the PCP to review the form and initiate a plan of care.

CCP providers are contractually bound to perform an HRA within the member's first 90 days of enrollment. The purpose is early identification of members who need CM/DM, may benefit from one or more healthy behavior programs and the identification of members who are behind in periodicity screening as delineated by screening guidelines.

DISEASE MANAGEMENT

PROGRAM OVERVIEW

Disease Management (DM) is 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 preventative in nature and engages the member as a partner of the healthcare team. CCP will work with providers and members/caregivers to improve clinical outcomes and system efficiencies. The goal is health management and illness avoidance as well as improved adherence to the treatment plan.

The DM program is a collaborative process that facilitates the development and implementation of appropriate courses of care (based on clinical practice guidelines) to meet a member's health care needs. Standardized programs for Cancer, Sickle Cell, HIV, CHF, Diabetes, Hypertension, Asthma, Behavioral Health and Substance Use Disorder have been developed. These programs include but are not limited to, practice guidelines, member education, provider education, and performance improvement measures. Additional DM Programs may be developed for other chronic illnesses as the need is identified. Those members who would benefit from interaction with a C3 Nurse Manager, but do not qualify for inclusion in established DM Programs, may be case-managed. Members can be referred by a PCP or can self-refer.

All members identified with the diagnosis of Asthma, Diabetes and/or Obesity are eligible for disease management.

Goals of the program are:

- Provide a high standard of health care services coordination
- Provide education to Members/Caregivers that will promote healthy behaviors and improve self-management skills
- Work with providers utilizing a collaborative approach to enhance the effectiveness of disease management and care coordination process
- Improve the health status of the community
- Earn member/caregiver and provider satisfaction

Driven by our community's responsibility to positively impact the health and wellness of those we serve, our main goal is to establish a planned and systematic process to maintain the promotion and delivery of high-quality physical and behavioral health care effectively and efficiently to all members.

The purpose of our DM program is to empower our members and their caregivers to optimally manage the identified condition(s). This involves extensive education and outreach to assist members in adopting healthy behaviors, accessing healthcare services at the appropriate time and location, as well as tracking the metrics of their conditions.

- Developing and coordinating appropriate initiatives and interventions and/or alternative care in conjunction with the member, providers, and other members of the care team.
- Assuring COC and coordination of high-quality services to promote healthy behaviors and to prevent complications of chronic diseases.
- Coordinating the optimization of health care resource utilization and ensuring the timely delivery of quality physical and behavioral health care services at the appropriate level of care.
- Promoting member and provider satisfaction with C3 DM education and care coordination processes.
- Promoting and assist in coordinating health care access and delivery in accordance with local, state, federal and accrediting agency standards.

Please note that CCP members may have participated in other DM programs, and with the assistance of CCP Care Managers will be transitioned in the CCP DM program.

To refer members to the DM program, please call CCP at 1-866-930-0944.

PCP ROLE

- Primary responsibility for medical management of enrollee
- Identify and refer 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 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 CCP enrollees may have participated in other disease management programs. They will now be part of the CCP Disease Management Programs and CCP Care Managers will assist in the transition.

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

Disease Management Department
1-866-899-4828

QUALITY MANAGEMENT

PROGRAM OVERIVEW

Community Care Plan 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. An explanation of monitor methodologies, along with benchmarks and performance targets can be obtained from CCP/ Quality Improvement Department. CCP may use practitioner performance data for quality improvement activities.

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

Well Child\Other Preventive Care

- Child and Adolescent Well-Care Visits (WCV)
- Well-Child Visits in the First 30 Months of Life (W30)
- Depression Screening and F/U for Adolescents (DSF)
- Immunization for Adolescents (IMA)
- Lead Screening in Children (LSC)
- Childhood Immunization Status Combo 3 & 10 (CIS)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Well-Child Visit (Child Health Check-Up)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children\Adolescents: All (WCC)

Adult Preventive Care

- Breast Cancer Screening (BCS)
- Chlamydia Screening for Women (CHL)
- Cervical Cancer Screening (CCS)
- Depression Screening and F/U for Adults (DSF)
- Adults Access to Preventive/Ambulatory Health Services (AAP)
- Ambulatory Care (includes ER measure) (AMB)
- Medical Assistance with Smoking and Tobacco Use Cessation

Other Chronic and Acute Care, including Comprehensive Diabetes Care

- Comprehensive Diabetes Care (CDC)
- Controlling Blood Pressure (CBP)
- Asthma Medication Ratio (AMR)
- Use of Pharmacotherapy for Opioid Use Disorder

Pregnancy Related Care

- Prenatal and Postpartum Care (PPC)
- Contraceptive Care All Women Ages 15-44 (CCW-AD)

Please submit a Notification of Pregnancy as soon as you confirm a member's pregnancy. This helps us offer any necessary support and services early in the pregnancy to achieve our common goal of healthy pregnancies and healthy babies.
Click here to access the form.

Mental Health

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)
- F/U After Hospitalization for Mental Illness (FUH)
- F/U After ED visit for Mental Illness (FUM)
- F/U After ED visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Antidepressant Medication Management (AMM)
- Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of multiple Concurrent Antipsychotics in Children and Adolescents (APC)

Additional information on Preventive Health Guidelines can be accessed at www.ccpcares.org.

ENROLLEE AVAILABILITY/ACCESSIBILITY TO SERVICES

Community Care Plan (CCP) providers are required to meet the following access to care standards:

- Emergency Medical Care - available 24 hours a day/7 day 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 day 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 call back by a licensed clinician.

CREDENTIALING AND RECREDENTIALING PROCESS

All providers must go through the CCP credentialing and contracting process. The CCP criteria include:

a. A copy of each Provider's current medical license pursuant to Section 641.495, F.S.
b. No revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitation of the Provider's State License by the Division of Medical Quality Assurance, Department of Health, or the Agency
c. Verification that the Provider is an approved Medicaid provider with an active Medicaid Provider number
d. Proof of the provider's medical school graduation, completion of residency and other post-graduation, completion of residency and other postgraduate training. Evidence of board certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training
e. Evidence of the Provider's professional liability claims history (National Providers Data Bank (NPDB) and Office of the Inspection General (OIG)
f. Any sanctions imposed on the Provider by Medicare and Medicaid or any Licensing Agency
g. Evidence of specialty board certification, if applicable
h. A satisfactory Level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program. (A provider without an Active Medicaid Provider Number)

1) Providers referenced above are required to submit fingerprints electronically following the process described on the Agency's Background Screening website. CCP shall verify the provider's Medicaid eligibility through the Agency's electronic background screening system.
2) CCP shall not contract with anyone who has a record of illegal conduct, i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.
3) Individuals already screened as Medicaid providers or screened within the past 12 months by the Agency or another Florida agency or department using the same criteria as Medicaid are not required to submit fingerprint electronically but shall document the results of the previous screening.
4) Individuals listed in s. 409.907 (8) (a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.

i. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106)
j. Evidence of peer review and peer reference

CCP performs an onsite review of provider sites to assure that a minimum standard is maintained in the delivery of quality of care. The review consists of two parts, a structured site visit review and a medical record/preventive care audit. CCP will re-credential providers at three-year intervals. In addition to being in good standing with the Agency for Health Care Administration (AHCA), the credentialing process will review applicants for re-credentialing using their achievement of quality indicators, compliance with medical record standards, conformity to access and site maintenance standards including infection control and safety control, grievance trending, peer review outcomes, and utilization management practices. Providers and provider staff will be required to provide proof of licensure, certifications and professional qualifications including continuing education commensurate with job requirements.

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 , gender, and legal guardianship (if any)
- Entries should be recorded timely, at the time care is given or as soon as is feasible given the situation
- Each record must contain a summary of significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medications and should be updated to reflect new allergies/problems/diagnoses.
- All records must contain all services provided by providers; such services must include, but not necessarily be limited to, family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- All records must contain documentation of referral services (including Health & Wellness Program if applicable), including reports of the results from the referral.
- Each record must be legible and maintained in detail.
- Each record must contain an immunization history.
- Each record must contain information on use of tobacco, alcohol, and drug/substances.
- Each record must contain a medication list and changes in prescription and non-prescription medication(s) with name and dosage, when available.
- Each record must contain a record of emergency services and care hospital discharges with appropriate, medically indicated follow up.
- 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 entries in each record must be dated and signed by appropriate party.
- 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 referrals and reports of completed studies/referrals should be contained in the record and acknowledged by the provider.
- 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., and O.D., including signature or initials of practitioner.
- All entries in each record must include the disposition, recommendations, instructions to the patient, evidence of informed consent including risk and adverse outcome, whether there was follow-up, and outcome of services. Including medication reconciliation. A copy of completed screenings is included in the enrollee record and is provided to the enrollee.
- Records must contain copy of any express written and informed consent of the enrollee's authorized representative or attestation form(s) for psychotropic

medications (i.e., antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years. In accordance with s.409.912(13),F.S., CCP ensures the following requirements are met:

- Prescriber documents the consent in the child's medical record and provides the pharmacy with a signed consent with the prescription
- Prescriber ensures completion of the appropriate attestation form from: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml
- The completed form is filed with the prescription in the pharmacy for a minimum of six (6) years.
- Pharmacies will not add refills to old prescriptions but will seek an updated informed consent
- Every new prescription requires a new informed consent form
- Informed consent forms do not replace prior-authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents under the age of eighteen (18) years.

- 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), including information on Chapter 765, F.S., 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. All records must contain copy of any advance directives executed by the enrollee (ages 18 and older including emancipated minors / for enrollees under 18 or not emancipated – documentation of offered/discussion with parent/guardian).
- All records must contain a Health Risk Assessment Form when one is returned by the enrollee and sent to the provider. This includes documentation of preterm delivery risk assessment by week twenty-eight (28) of pregnancy. A copy of the completed screening tool becomes part of the medical record, and a copy is provided to the enrollee.
- All records must contain documentation of significant findings and medical advice given to enrollee in person, by telephone, online or provided after-hours.
- Records of enrollee treated elsewhere or transferred to another health care provider are present.
- All records must contain a brief explanation of the use of telemedicine in each progress note; documentation of telemedicine equipment used for the particular covered services provided; and a signed statement from the enrollee or the enrollee's representative indicating their choice to receive services through telemedicine (This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided), for services provided through telemedicine.
- Environmental and/or or special needs (e.g., safety, sanitation, need for physical adaptations, general condition of the home, amount of space, adequacy of sleeping area, access to bathroom, temperature, availability of food, etc.).
- Documentation of missed or cancelled appointments and subsequent follow up

PEER REVIEW

It is the intent and purpose of Community Care Plan to continually improve the quality of the level of care and service provided to CCP 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, included in this provider handbook, 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 access the performance of all primary care providers, including Family Physicians, Internists, General Practitioners, Pediatricians, Obstetrician/Gynecologists and Advance Registered Nurse Practitioners (ARNP).

The peer review responsibilities reside in a committee or committees of licensed physicians who are enrollees of the physician network of that specific hospital system. Responsibilities minimally include:

1. Review of credentialing and re-credentialing applications
2. Following CCP'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

CCP'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 CCP 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 or (4) Medicare Provider numbers revoked or suspended, he/she must **IMMEDIATELY** notify CCP. The revocation or suspension of any of the above licenses or numbers will lead to an automatic suspension of the provider's CCP contract. The provider may re-apply to become a CCP 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 CCP. The appellate process may be initiated by the provider contacting the Medical Director. CCP 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 CCP network either on a temporary or on a permanent basis.

The Agency for Health Care Administration will be receiving CCP quality indicator outcome reports as defined in the quality management section of this manual. CCP in turn will be closely monitoring minimally these same quality indicators and the Generic Outcome screen Indicators (GOSI) in order to evaluate the performance of providers.

WELL-CHILD VISIT (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 preventative and comprehensive service for eligible children, from birth up to 21 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 lab tests (including testing for lead poisoning); appropriate immunizations (shots); health education/anticipatory guidance; diagnosis and treatment; 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.

IMMUNIZATION

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. We provide this assistance via the Provider Hotline or by contacting the Provider Representative assigned to your area directly. Information regarding the Vaccine for Children Program can be obtained directly by calling 1-800-483-2543 or by going to:
www.doh.state.fl.us/DISEASE_CTRL/immune/vfc/index.html

BLOOD LEAD SCREENING

CCP CHCUP guideline includes Blood Lead Level Screenings for children from the ages of nine months through 72 months. As licensed health care professionals, you are aware that performing a blood test for lead is a federal requirement at specific intervals during the "Child Health Check-Up" (CHCUP). This note is to remind you how important it is to document the blood tests you are performing in compliance with this federal mandate. The federal regulation as referenced in the Child Health Check-Up Coverage and Limitations Handbook requires that all Medicaid children receive a screening blood lead test at the ages of ***12 months and 24 months***, and between the ages of 36 months and 72 months if they have not been previously screened for lead poisoning. The CPT code for the blood lead testing is ***83655***.

GENERIC OUTCOME SCREENING INDICATORS (GOSI)

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

CRITERIA

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

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

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

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

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

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

CRITERIA
17. **Quality of Care—Adverse or unexpected outcomes**
18. Performance of Medically Unnecessary Procedures
19. **Sentinel events, such as:** A. The death of a patient B. Brain or spinal damage to a patient C. The performance of a surgical procedure on the wrong patient, or D. The performance of a wrong –site surgical procedure E. The performance of a wrong surgical procedure F. The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition G. The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process H. The performance of procedures to remove unplanned foreign objects remaining from surgical procedure I. Infant abduction or discharge to the wrong family J. Suicide or attempted suicide of patient K. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibility L. Patient escape/elopement M. Sexual battery on a patient N. Abuse, Neglect and Exploitation

RISK MANAGEMENT

All network providers must participate in and cooperate with Community Care Plan (CCP) Risk Management Program. CCP developed and implemented an incident reporting system to minimize injury/incidents to our enrollees, employees or visitors. The Risk Management Program and incident reporting policy and procedures comply with 59A-12.012, Florida Administrative Code and 641.55, Florida Statute.

ADVERSE INCIDENT

An event, as defined in Chapter 395.0197(5) of the Florida Statutes, over which health care personnel could exercise control, which is associated, in whole or in part, with the medical intervention rather than the medical condition for which such medical intervention occurred which results in one of the following:

A. Death
B. Brain or spinal damage
C. Permanent disfigurement
D. Fracture or dislocation of bones or joints
E. Elopement
F. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility
G. Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than as Emergency Medical Condition, to which the enrollee has not given his/her informed consent

H. Any condition that required the transfer of the enrollee, within or outside the facility, to a unit providing a more acute level of care due to the Adverse Incident, rather than the enrollee's condition prior to the Adverse Incident, including:

1. The performance of a surgical procedure on the wrong patient, a wrong surgical procedure or wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the enrollee's diagnosis or medical condition
2. Required surgical repair of damage resulting to an enrollee from a planned surgical procedure where the damage was not a recognized specific risk, as disclosed to the enrollee and documented through the informed-consent process
3. A procedure to remove unplanned foreign objects remaining from a surgical procedure
4. Any complaint or allegation of sexual misconduct and abuse, or contact by Provider employee or agent of Provider

If an **Adverse Incident** occurs to an enrollee, Provider must report the incident, as required by the Agency of Healthcare Administration, to CCP's Risk Manager within **twenty-four (24) hours** after the incident.

Provider must:

- Cooperate with the CCP's Risk Management Program
- Provide such medical and other records without charge within ten (10) days of report and/or request or upon of receipt of written notice
- Share such investigation reports and other information as may be required or requested by CCP's Risk Manager to determine if an Adverse Incident is reportable as a "Code 15" to AHCA

When an incident occurs:

- Complete the Incident Report form (see attached) immediately when becoming aware of an Adverse Incident
- Fill each blank on the form, using N/A when something is not applicable to the particular occurrence
- Write legibly or type the information on the form
- Describe the incident carefully
- Indicate the body part injured location and extent of injury and document fully, including lack of injury
- Report any pertinent action taken in response to the occurrence
- Obtain the name and location information for any witness, including employees
- Sign and date the report. Include title/designation and contact phone number
- Fax to CCP's Risk Management at: 954-251-4161

For assistance in completing the Incident Report form, please contact CCP's Risk Manager at 954-622-3327. (Please see page 63 for a copy of the Adverse Incident Form).

Note: Incident Reports are part of risk management files only and copies of Incident Reports must be maintained separately from Enrollee's medical record. All Incident Reports will be reviewed, and date stamped upon receipt. Appropriate action will be initiated when indicated. Incident Reports will not be used to penalize Providers; however, failure to report an Adverse Incident may result in further action by the CCP.