Community Care Plan
The Health Plan with a Heart

2022 Florida Healthy Kids Provider Manual

HealthyKids™
a Florida KidCare partner

www.CCPHealthyKids.org

1643 Harrison Parkway, Building H, Suite 200

Sunrise, Florida 33323

Effective 1/1/2022

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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 Florida Healthy Kids Corporation (FHKC) to serve the Florida Healthy Kids membership in Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, and St. Lucie, effective January 1, 2020. 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.

This Provider Manual is intended to be used as an orientation tool and guideline for the provision of covered services to members. This Provider Manual outlines the policies, procedures, and programs you have agreed to comply with, as presented in the Provider Services Agreement between you and CCP. We request your expertise to ensure that the care provided to our members meets the performance standards and indicators as outlined in this manual. As a network provider, we ask that you review the information to better understand the importance of your role in the provision of services to our members and compliance with the program requirements.

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.

A contact list of important phone numbers is included on the next page for your convenience. Should you have any questions or require further information about the program or policies contained in this manual, we urge you to call your Provider Operations Department.

You are a key part of the continuing success of CCP, and we look forward to a very rewarding business relationship.

Thank you,

Community Care Plan

IMPORTANT CONTACTS

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: 1-866-930-0944
Case Management	**Disease Management**
Phone: 1-866-930-0944	Phone: 1-866-930-0944
24-hour Nurse Helpline	**Emergency 24/7 Behavioral Health Crisis Hotline**
Phone: 1-855-541-6404	Phone: 1-877-400-4999
Claims/Billing	
Electronic Claims: Community Care Plan (Healthy Kids) Availity Payer ID: FHKC1	Claims with attachments should be mailed to: CCP Claims Department PO BOX 841209 Pembroke Pines, FL 33084
Claim Timely Filing	**Claims Inquiries**
180 days from date of service or date	Phone: 1-866-930-0944
Prior Authorization Inquiries	**Fraud & Abuse Hotline**
Phone: 1-866-930-0944	Phone: 1-888-419-3456
Web Portal- Plan Link	**Translation Services**
http://planlink.ccpcares.org/	Phone: 1-866-930-0944
Vendors	
Pharmacy	Magellan Pharmacy Solution 1-800-424-7906
DME	Coastal Care Services, Inc. 1-833-204-4535
Home Health	Coastal Care Services, Inc. 1-833-204-4535
PT, OT, ST	Health Network One (HN1) 1-888-550-8800
Vision	South FL Vision/2020/iCare 1-877-296-1299
Transportation	ModivCare 1-866-430-0570

COVERED SERVICES

Covered Services	Coverage Limits	Copays
Well-child care, including preventive care visits, immunizations (shots), and routine hearing and vision screenings	• Hearing and vision screenings and immunizations must be provided by the member's Primary Care Physician (PCP).	$0 copay
PCP Office Visits	• Member must use a CCP in-network provider.	$0 copay
Specialist Office Visits	• Member must use a CCP network provider. • Member must be referred by their assigned PCP.	$5 per visit
Diagnostic Testing (laboratory, radiology, and other diagnostic tests)	• Member must use a CCP network provider. • Member must meet medical necessity requirements. • Some diagnostic testing services may require approval from CCP.	$0 copay
Prescription Drugs (generic drugs, unless the brand name is medically necessary)	• Member must use a CCP in-network pharmacy. • Must be prescribed by members PCP or a CCP in-network provider.	$5 copay per prescription, up to a 31-day supply
Inpatient Hospital Stays (semiprivate room)	• Must use a CCP in-network hospital. • Stays must be approved by CCP. • Limited to 15 days per year for rehabilitation and physical therapy stays.	$0 copay
Chiropractic services	• Must use a CCP network provider • Limited to one visit per day for up to 24 visits per calendar year.	$5 per visit
Podiatric Services	• Must be provided by a CCP network provider • Limited to one visit per day for up to two visits per month for certain foot disorders.	$5 per visit
Maternity services and newborn care, including prenatal and postpartum care, and the initial inpatient care of the newborn	• Must use a CCP network provider. • Coverage for the newborn limited to three days after birth.	$0 copay

Covered Services	Coverage Limits	Copays
Family Planning Services	• Must be provided by a CCP network provider. • Limited to one visit per year and one supply visit every 90 calendar days.	$0 copay
Emergency services, including visits to an emergency room	• Members have the right to go to any hospital or provider if the time to reach a CCP network provider would risk permanent damage to their health. • Members may also contact their PCP or CareNet, our 24-hour Nurse Helpline, at 1-855-541-6404.	$10 per visit, waived if admitted or authorized by child's PCP.
Emergency Transportation Services	• Transportation in response to an emergency medical condition.	$10 per trip
Vision services	• Members have the right to receive vision screening as part of preventive health care services. • Covered services include an examination to determine the need for and to prescribe corrective lenses as medically necessary. • Members can receive one new pair of glasses every two years unless the prescription changes or there is a change in the child's head size. • Please call 20/20 EyeCare Network at 1-877-296-1299 to obtain provider and preapproval information.	$5 per visit with specialist $10 for corrective lenses
Behavioral Health Services, including inpatient and outpatient care for psychiatric evaluation, diagnosis, and treatment	• Inpatient services that are not an emergency need preapproval.	$0 copay for inpatient services $5 per office visit
Substance Use Disorder Services, including inpatient and outpatient care for drug and alcohol abuse (such as counseling and help with placement assistance)	• Inpatient services that are not an emergency need preapproval.	$0 copay for inpatient services $5 per office visit

Covered Services	Coverage Limits	Copays
Nursing facility services, including regular nursing services, rehabilitation services, semiprivate room	• Must be approved by CCP and provided by a network facility. • Limited to 100 days per year (rehabilitation and physical therapy stays are limited to 15 days per year) • Excludes private duty nurses, television, custodial care, specialized treatment centers, and independent kidney disease treatment centers	$0 copay
Short Term Rehabilitation Therapy Services, including physical, occupational, and speech therapies for short-term rehabilitation when the child's condition is expected to significantly improve	• Limited to 24 sessions within a 60 Calendar Day period per incident. The 60 Calendar Day period begins with the first treatment. • Please call HN1 at 1-888-550-8800 to obtain provider and pre-approval information.	$5 per visit
Short Term Respiratory Therapy Services, for short-term rehabilitation, when the child's condition is expected to significantly improve	• Limited to 24 sessions within a 60 Calendar Day period per incident. The 60 Calendar Day period begins with the first treatment.	$5 per visit
Home Health Services, including prescribed home visits by registered and licensed practical nurses to provide skilled nursing services on a part-time intermittent basis	• Limited to skilled nursing services. • Meals, housekeeping, and personal comfort items are excluded. • Private duty nursing is covered if medically necessary. • Please call Coastal Care Services at 1-833-204-4535 to obtain provider and preapproval information.	$5 per visit
Hospice services, including reasonable and necessary services to manage a terminal illness	• Must be approved by CCP. • Covered services include prescribed home visits by registered or licensed practical nurses to provide skilled nursing services on a part-time intermittent basis. • Limited to skilled nursing services only. Meals, housekeeping, and personal comfort items are excluded. • Private duty nursing is limited to circumstances where such care is medically necessary.	$5 per visit $0 for inpatient services

Covered Services	Coverage Limits	Copays
Durable medical equipment (DME) and prosthetic devices if prescribed by the members CCP provider as medically necessary	• Some services may require approval by CCP. • Covered services include prescribed equipment and devices that are medically indicated to assist in the treatment of a medical condition. Covered prosthetic devices include artificial eyes, limbs, braces, and other artificial aids. • Low-vision and telescopic lenses are not included. • Hearing aids are covered only when medically indicated to assist in the treatment of a medical condition. • Please call Coastal Care Services at 1-833-204-4535 to obtain provider and preapproval information.	$0 copay
Organ transplant services, including care before, during and after the transplant, and treatment of complications after the transplant	• Must be deemed necessary and must be provided by a CCP network provider and approved by CCP	$0 copay

VALUE-ADDED BENEFITS

Value-Added Benefits	Coverage Limits	Copays
PCP Office Visit Copay Waiver	• To ensure members receive all needed care from his/her PCP, CCP has waived the copays for any visit provided by the member's PCP. • There is no limit to this benefit.	$0 Copay
Sports/School Physical Copay Waiver	• CCP members are eligible for an annual school or sports physical provided by the member's PCP with no co-pay. • Limited to one physical per member per year.	$0 Copay
Transportation for Medical and Dental Preventive Services	• CCP provides non-emergent transportation to members, and up to two companions, to medical or dental preventive exams. • Reservations must be made at least 72 hours prior to the appointment. • Trips over 25 miles require prior authorization.	$0 Copay

Value-Added Benefits	Coverage Limits	Copays
Medically related Lodging (Reimbursement for lodging related to medical care outside of service area)	• Must be approved by CCP. • Benefit limited to $150 per episode of care when medical services are not available within the CCP service area. • Members must provide proof of relevant expenditures to receive reimbursement.	$0 Copay
Hypoallergenic Bedding	• CCP provides up to $100 per year of hypoallergenic bedding for members with an appropriate diagnosis of allergies or asthma for whom hypoallergenic bedding is medically necessary.	$0 Copay
Provider House Calls	• CCP offers home visits by a licensed provider to members who are homebound and need follow-up treatment. • Must be approved by CCP • Limited to 20 visits per year.	$0 Copay
Health Risk Assessment (HRA) Incentive	The HRA helps CCP better understand members' health needs. To encourage completion of the HRA, CCP provides a onetime incentive of: • A $25 gift card for completing the HRA within 30 Calendar Days of enrollment, • A $20 gift card for completing the HRA within 60 Calendar Days of enrollment, or • A $15 gift card for completing the HRA within 90 Calendar Days of enrollment. • This is a one-time benefit.	$0 Copay

Value-Added Benefits	Coverage Limits	Copays
Healthy Behavior Coaching	CCP offers individualized, in-person coaching programs for the following health behaviors: • Tobacco/Nicotine cessation • Substance use disorder and • Medically necessary supervised nutrition counseling for members in need of weight management. • Program length is six months • To support the member and family, case management will be provided to track progress and remove barriers to success.	$0 Copay
Obesity Program **"Food, Fun, and Fit"**	• In partnership with other community organizations, CCP offers a series of three education workshops to address childhood obesity. Members will learn about healthy eating and adopting a healthier lifestyle • This program is tailored to each participating member and will include a self-management assessment tool upon enrollment in the program, at three, six-, and 12-months enrollment. As an incentive, each participating family receives a Bluetooth enabled scale to help them and their PCP track the child's progress. • All children aged 5-18 with a BMI at or above the 95th percentile for children and teens the same age and sex, as defined by the Center for Disease Control and Prevention (CDC) and the American Academy of Pediatrics are eligible for this program • Onetime benefit	$0 Copay
Water Safety Classes **"Swim, Seconds, and Safety"**	• CCP provides water safety and drowning prevention classes to all members. • Members can request this benefit by contacting CCP Member Services • Limited to one set of classes per member per lifetime	$0 Copay

Definitions:

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

1. Meet the following conditions:
    a. Be necessary to protect life to prevent significant illness or significant disability or to alleviate severe pain
    b. Be individualized, specific and consistent with symptoms or confirm a 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 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 member, the member'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, medical necessity or a covered service/benefit.

Well-Child and Adolescent Visits & Immunizations:
A well-child/adolescent health checkup is a routine health screening evaluation of children ages 5 to 18 that includes a comprehensive health and developmental history; hearing, vision, updating of routine immunizations; and referrals for further diagnosis and treatment as needed.

Providers are encouraged to assist members 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 access it at http://brightfutures.aap.org.

Maternity Care:
All pregnant members will be offered a choice of a participating obstetrical doctor or nurse-midwife for prenatal care and delivery of the newborn. All females of childbearing age will be offered counseling, testing, and treatment of blood-borne diseases that may affect them or their unborn child. Coverage for the newborn is limited to three days after birth.

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

Hospital:
Hospital Inpatient Care includes all inpatient services authorized by CCP: room and board, nursing care, and medical supplies, diagnostic and therapeutic services. There is no limit on the number of inpatient days for recipients 18 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.

Family Planning:
The purpose of family planning services is to allow members to make informed decisions about family size and/or spacing of births.

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 Florida Healthy Kids include eyeglasses, eyeglass repairs as required, prosthetic eyes and contact lenses.

PROVIDER RESPONSIBILITIES

Provider Services and Contracting

Providers who participate in CCP shall render medical care to members of CCP, pursuant to all laws and regulations applicable to the provider and CCP. This section outlines general provider responsibilities; however, additional responsibilities are included throughout the manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the Florida Healthy Kids Program, your Provider Agreement, and requirements outlined in this manual. Providers must cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, the Florida Healthy Kids Corporation, Department of Health (DOH), the Medicaid Fraud Control Unit (MFCU), Health and Human Services – Office of Inspector General (HHS-OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney's Office. A provider must complete an application, Provider Agreement and be fully credentialed to be approved for participation.

Providers are responsible to notify our Provider Operations Department on any changes in professional staff at their locations. This includes any physicians/medical director, physician assistants, or clinician practitioners. CCP understands that changes in office staff may result in the need for additional training. Contact our Provider Operations Department to schedule staff training.

Providers terminating their contracts without cause are required to provide a 60-day notice before terminating with CCP. The provider must also continue to treat members until the treatment course has been completed or care is transitioned. An authorization may be necessary for Continuity of Care (COC) services.

Verification of Enrollment

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. Providers are NOT reimbursed for services rendered to members who have lost eligibility. The provider is responsible for verifying a member's current enrollment status before providing care. 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 Customer Experience for assistance with specific enrollee issues.

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 Operations. The provider may file a non-claim related complaint within 45 calendar days of the event.

CCP's dedicated Provider Operations Department is available during regular business hours via telephone, electronic mail, or in-person to ask questions, file a complaint and/or resolve problems. The Provider Operations Department 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. To file a provider complaint, please submit it via e-mail to ccp.provider.ccpcares.org or write to:

COMMUNITY CARE PLAN
1643 Harrison Parkway, H-200
Sunrise, FL 33323
Attention: Provider Operations

COC Requirement for New Members

CCP is dedicated to coordinate care for all new members enrolled in the plan. The coordination of care ensures all new members receiving medical treatment through a previous health plan 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 a participating or non-participating provider. CCP will aid with the coordination of care for the new members.

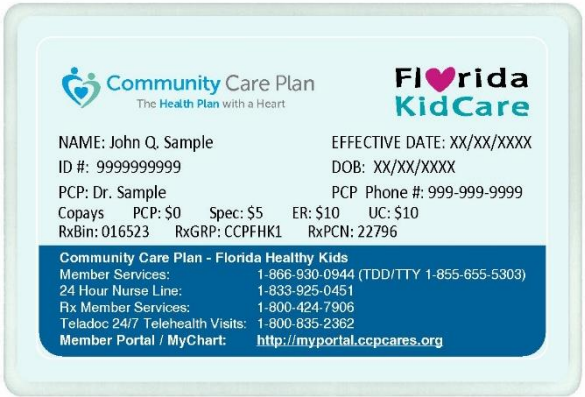
During the first sixty (60) days of a member in the plan, CCP will reimburse non-participating providers the rate they received for services prior to enrolling in CCP.

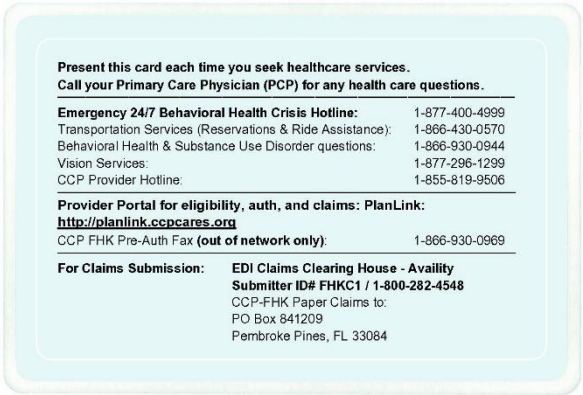
CCP will provide continuation of services until the member's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively), reviews the new member's treatment plan. The continuation of care shall be no more than sixty (60) calendar days after the effective date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

ID Cards

Each CCP member will receive from CCP an identification card. This card is used to help identify the member of his/her eligibility in the CCP plan. Please note, sole possession of an identification card does not guarantee current CCP eligibility. The provider must verify eligibility by using CCP Provider Web Portal or by calling Member Services. Members are asked to carry this card at all times.

Sample Community Care Plan – Florida Healthy Kids Member ID Card





PCP Responsibilities, Procedures, and New Member Processing

To encourage members to visit their PCP, the CCP Member Services Department will contact each new member by mail through an introductory letter that includes the name, address, and phone number of the member's PCP. The mailing includes information regarding CCP benefits and it requests members to make an appointment with his/her PCP for an initial health assessment. The mailing also includes an HRA and Medical Release Form. A postage-paid envelope is provided to members for return to CCP. When the HRA is received by the CCP Case Management Department, a nurse will review it to identify any need for the member to be followed by case management or possibly benefit from a CCP Disease Management (DM) or Healthy Behaviors Program. The original form with valuable information will then be forwarded to the PCP for review, action, and for final placement in the member's medical record. If you have not already initiated a medical record for the member, one should be created at this time.

In addition to the contact by CCP, PCP's should welcome their new members and request they seek an initial health screening. Be sure to document any attempts to reach the member in the member's medical record. At the first visit, members should be requested to authorize the release of their medical records to you, their new PCP. PCPs are required 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 can 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.

PCPs shall provide, or arrange for coverage of services, consultation, or approval for referrals twenty-four hours per day, seven days per week (24/7), including but not limited to an answering service, call forwarding, provider call coverage or other customary means. 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.

PCPs 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.

PCP Responsibilities with Non-Compliant Members

PCP's have a responsibility to respond to members who either fail to show or follow a provider's plan of care as this can lead to a delay or failure on the part of the member to get medical diagnosis or treatment. The member needs to be notified of his/her non-compliance and the provider needs to document this activity whether done verbally or in writing. CCP will be monitoring this activity. A provider may request to remove a non-compliant member from their panel upon documenting the activity.

- "Failure to show" is defined as a member who has missed three 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 the plan of care" is when a member chooses not to comply with the prescribed plan of care.

- "Provider Request to Remove a Member from PCP Panel" occurs when providers are unable to maintain a satisfactory relationship with the member due to non-compliance. Such requests need to be communicated to your Provider Operations Department. Each case will be evaluated individually to ascertain if a change in PCP is an option. After ample notification by the provider, if the member fails to correct the situation, the PCP should notify the member and provider by certified mail of the request to terminate his/her relationship with the member as their PCP. The PCP is expected to continue providing care until the effective date of the change. The PCP should instruct the member to seek assistance from the CCP Member Services Department at 1-866-930-0944.

Specialist Responsibilities

The specialist may order diagnostic tests without PCP involvement by following CCP's referral guidelines. The specialist must abide by the prior authorization requirements when ordering diagnostic tests, except in a true emergency. All non-emergency inpatient admissions require prior authorization from CCP. The member's PCP is responsible for coordinating the provision of specialist services. The Specialist and the PCP shall work together to coordinate medical care for the member.

Billing and Payment for Services

PCPs

PCPs will receive compensation at the agreed-upon rate for covered services.

Specialists and Ancillary Providers

Specialists and ancillary providers will receive compensation at the agreed-upon rate for 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. Other than applicable co-payments, providers shall accept no payment from CCP members, the members' relatives or any other person or persons in charge as the members' designated representative, in excess of the reimbursement rate made by the plan.

In no event, including, but not limited to, non-payment by CCP, 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 member, other than CCP,

acting on the members' behalf, for contracted services pursuant to your Provider Services Agreement.

Copayment Collections

Members may have a co-payment 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. This deduction occurs whether the provider collects it from the member.

Third-Party Liability (TPL) Cases

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

Claims Submissions

Providers are required to submit all claims within 60 days of the date of service. Claims submitted after a six-month period from the date of service will automatically be denied by CCP for untimely filing. Providers shall submit claims in accordance with applicable state and federal laws. Unless otherwise stated in the Provider Agreement, the following guidelines apply.

Provider shall submit clean, complete, and accurate claims to CCP or its designated clearinghouse, via an 837 HIPAA compliant electronic media format. Provider agrees to work with CCP contracted clearinghouses. The advantages of electronic claims submission include, but are not limited to, increased speed of payments, reduced data entry errors, less paper and decreased clerical costs.

Providers may also submit claims that require attachments or reconsideration requests via paper. All paper claim forms must be complete and accurate containing all data fields necessary for the claim to be considered clean.

COMMUNITY CARE PLAN (CCP)
CLAIMS DEPARTMENT
Availity Payor ID FHKC1

Claims with attachments should be mailed to:
CCP Claims Department
PO BOX 841209
Pembroke Pines, FL 33084

CCP Electronic Claims Clearinghouse Vendor: **Availity Payor ID FHKC1**

www.availity.com

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

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

Claims Payments
CCP will pay claims at the agreed rate less any applicable co-payments directly to the provider. If you have inquiries regarding late claim payment or have other claim inquiries, please utilize our provider portal PlanLink. Should you need to speak with a customer service representative regarding a claim inquiry, please call 1-866-930-0944.

Electronic Funds Transfer (EFT)
Electronic funds transfer offers electronic payments deposited directly into providers' bank accounts. An EFT can improve the consistency of your payments and provide fast, accurate and secure payments directly into your bank account. Please allow 45 days for processing once the enrollment form is received. Please see the EFT form in the forms section at the end of this manual.

Provider Claims Appeals
If a claims denial is received from CCP and you are requesting reconsideration of your claim, you must complete a Claims Reconsideration Form (located in the **Forms** section of this manual) and mail to:

COMMUNITY CARE PLAN (CCP)
PROVIDER/CLAIMS APPEALS
P.O. Box 841209
Pembroke Pines, FL 33084

Providers may also email the Provider Operations Department at ccp.provider@ccpcares.org or call CCP's Provider Operations Department at 1-855-819-9506 to file a claims complaint.

Provider Identified Overpayments
Once an overpayment has been identified by the provider, CCP must be notified within 60 days. Any overpayment notification must be accompanied by an itemized list of additional information or documents CCP can reasonably determine are necessary to process the refund, if applicable.

Provider Responsibilities for Address and Practice Changes

Office Changes
It is imperative that you notify the Provider Operations Department of changes in your practice prior to the effective date of the change. This information is essential for CCP's Provider Directory accuracy. 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 Providers
When a new provider is being added to your practice, please contact Provider Operations to obtain a provider credentialing application. To be a participant in the CCP network, the provider must have an active Florida Medicaid provider number. The new provider must complete the application

process and obtain credentialing approval prior to participation in the CCP network.

PCPs Requesting to Close Panel

PCPs must submit to CCP in writing any requests to close their panel. This letter needs to include the reason for closing their panel and an estimated time frame for the non-acceptance of members.

Providers Requesting Termination

A CCP provider wishing to terminate their agreement 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 the expiration of the sixty (60) day advance written notice. The provider must also continue to treat members until the treatment course has been completed or care is transitioned. Pregnant members can continue receiving services through postpartum care.

Pharmacy Services

Prescription drugs are covered when ordered by an in-network CCP provider. Some medications may require prior authorization or have limitations based upon the member's age, drug dosage and/or maximum quantity limits. 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. The CCP Preferred Drug List (PDL) can be accessed at www.CCPHealthyKids.org.

Working with our Pharmacy Benefit Manager (PBM)

CCP contracts with Magellan Pharmacy Solutions to process all pharmacy claims for prescribed drugs. Prior authorization is required for medications listed as PA on the PDL, and those not listed on the PDL.

When requesting prior authorization, please use the Community Care Plan - Florida Healthy Kids Pharmacy Prior Authorization (PA) Request Form available on our website (www.CCPHealthyKids.org) and include the Member 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, the information in the on-line pharmacy claims processing system will be changed to allow the specific member to receive this specific drug. If the request is denied, information regarding the denial will be provided to the prescribing provider.

Prior Authorization Phone:	800-424-7906
Prior Authorization Fax:	866-291-3728
Mailing Address:	Clinical Operations Department Community Care Plan (CCP) C/o Magellan Pharmacy Solutions 11013 West Broad St., Suite 500 Glen Allen, VA 23060

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 member'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 and 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

Fraud, Waste, Abuse, and Overpayment

CCP is committed to preventing, reducing, detecting, investigating, correcting, and reporting known or suspected fraud, abuse, overpayment, and waste activities. The CCP provider network must cooperate fully in making personnel and/or subcontractor personnel available for in-person interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

CCP works to detect and prevent potential healthcare and insurance fraud, waste, abuse, and overpayment through a variety of sources and using detection technology.

Prevention and detection activities include but are not limited to:

- Tips from CCP employees, members, providers, other insurers and/or the public
- Data mining/data analysis
- Alerts from the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) and/or Agency for Health Care Administration (AHCA) Medicaid Program Integrity (MPI)
- Pre-payment and post-payment review processes
- Provider profiling
- Review of prior authorization requests and/or UM.

When CCP determines an overpayment has been made to a provider for services to a CCP member, notice documenting the basis for the overpayment is sent to the provider. The documentation includes identification of the specific claims for which CCP is recovering overpayment funds from the provider. The provider must pay, deny or contest CCP's claim for overpayment within 40 days of receipt of the notice. Failure of the provider to respond to a notice of overpayment will result in recoupment.

During the process of engaging services with subcontractors, vendors, and providers and during the renewal of agreements and re-credentialing, CCP will conduct checks to ensure that it does not

contract with any entity that is in nonpayment status or excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act, including Medicare, Medicaid, and CHIP. Vendors, subcontractors, and providers will be checked on at least a monthly basis against the federal List of Excluded Individuals and Entities (LEIE), the federal System for Award Management (SAM) and the AHCA listing of suspended and terminated providers.

CCP providers must have an effective compliance program that at a minimum, includes the seven core compliance program requirements (42 C.F.R. §438.608) and is essential to preventing, detecting, and correcting CCP-Florida Healthy Kids non-compliance as well as fraud, waste, and abuse. Providers should provide detailed information and training to their employees about the False Claims Act, including information on the rights of employees to be protected as whistleblowers. Information should also be included on Anti-Kickback Statute and Stark Law. Provider training & attestation of training can be found at www.CCPHealthyKids.org. Attestations of compliance training completion should be emailed to CCP.Compliance@ccpcares.org.

Provider organizations should have mechanisms in place to report potential fraud, waste, or abuse. Provider organizations must be able to accept anonymous reports and cannot retaliate against a person for reporting. Suspected instances of Fraud, Waste and Abuse can be reported directly to CCP. This can be done anonymously by calling 855-843-1106 or going to: www.lighthouse-services.com/ccpcares.

Providers can also contact the CCP Compliance Officer at 954-622-3489 or via email at CCP.Compliance@ccpcares.org or CCP.SIU@ccpcares.org.

To direct report suspected fraud, waste, or abuse in the CHIP or Medicaid Program or any other CCP program, please use one of the following avenues:

- The Florida Medicaid Program Integrity (MPI) Office: 1-850-412-4600 or
- AHCA-MPI Consumer Complaint Hotline: 1-888-419-3456 or
- AHCA-MPI Medicaid Fraud and Abuse Complaint form https://apps.ahca.myflorida.com/mpi-complaintform/ or
- Florida Attorney General's Office: 1-866-966-7226 or
- Report Insurance Fraud to Florida's Chief Financial Officer at https://first.fldfs.com/ or 1-800-378-0445
- Department of Health and Human Services Office of Inspector General (HHS-OIG) Hotline: 1-800-447-8477
  Member Fraud Related to Public Assistance
  https://www.myflfamilies.com/service-programs/public-benefits-integrity/

Cultural Competency

All providers are expected to be aware of the cultural backgrounds of the patients they serve and to be sensitive toward issues of cultural diversity and health literacy. Providers should post clear, 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. Staff training should include information about cultural diversity, the importance of non-verbal communication, inpatient care, and identifying and addressing patients with health literacy issues. Providers need to ask each patient about their language preference and include the information in their medical record. 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 members and protects and preserves the dignity of each. Providers can access the full CCP Cultural Competency Plan at www.CCPHealthyKids.org or by calling Provider Operations.

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 report the adverse incidents to the CCP Risk Manager within twenty-four hours of the incident. (See CCP Potential Quality Incident form (located in the **FORMS** section of this manual) Reporting will include the following information: member's identity, description of the incident and outcomes including the current status of the member. If the event involves a health and safety issue, the CCP Case Manager will assist to relocate the member 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 member's case file, that is designated as confidential.

Provider Access and Accessibility

Providers are expected to provide care to members in a timely manner. CCP monitors the following:

- Primary Care Appointment
- After-hours Access
- Specialty Care
- Behavioral Health Practitioner Appointment Accessibility

TIMELY ACCESS REQUIREMENT

CCP measures primary care and specialty care appointment access through a survey of physician offices. All offices are included in data collection.

The survey process consists of the following:

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 that have access issues since the 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.

MEMBER INFORMATION

Member Services

The primary responsibility of the Member Services Department is to facilitate and guide members in accessing health care services and information about CCP, focusing on the following:

- Orient and educate new members
- Determine and answer eligibility questions
- Provide information on covered and non-covered services
- Educate members on CCP processes and services
- Provide referral/authorization status
- Provide enrollment status
- Direct members to appropriate departments/resources
- Generate member access to services
- Facilitate member access to services
- Receive and process member 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 the quality of services and customer satisfaction
- Receive and process PCP assignment and transfer requests

PCP Assignment

Every CCP member must have a CCP PCP assigned. This PCP will handle the member's primary care medical needs and will coordinate for specialty and hospital care when necessary.

When a member comes on board with CCP, they will either choose a PCP or be assigned one if he/she fails to make an active choice. If a new member has chosen a group practice by name or has been assigned to a clinic setting, the provider office will assign the member to a PCP. The assigned PCP should be the provider best fit to facilitate COC.

PCP Transfer Requests

CCP strives to maintain a positive relationship between members and their PCPs. If a member or a member's legal guardian would like to request a PCP change, they may do so by calling the CCP Member Services Department at 1-866-930-0944. If a PCP change is made, the member will receive a new ID Card from Member Services indicating the new PCP name.

Healthy Behavior Programs

CCP offers our members individualized, in-person coaching programs for the following:

- Smoking cessation, including electronic cigarettes (e-cigarettes/vaping)
- Substance Use Disorders
- Medically supervised nutrition counseling for members in need of weight management

These programs vary in length from 12 weeks to six months. To support members and their families, case management will be provided to track progress and remove barriers to success.

Food, Fun, and Fit

In conjunction with other community organizations, CCP has created the "Food, Fun, and Fit" program which offers a series of three education workshops to address childhood obesity. This program teaches the child and family how to make healthy choices, includes hands-on meal preparation and incorporates exercise in a fun way. This program is for members aged 5-18 who have a BMI at or above the 95th percentile for children and teens the same age and sex, as defined by the American Academy of Pediatrics. To help the provider and family to track the child's progress, each family will receive a Bluetooth-enabled scale. This program is a one-time benefit for each member.

Member Rights and Responsibilities

In accordance with 42 CFR 438.100, CCP is committed to treating members with respect and dignity, while striving to improve health outcomes. To ensure this, member rights and responsibilities are shared with staff, providers, and members each year. CCP provider contracts require you to comply with the outlined member rights and responsibilities within.

It is CCP's policy not to discriminate against members based on race, color, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities below.

If CCP is made aware of an issue with a member not receiving the rights as identified above, CCP will initiate an investigation and report the findings to the Quality Management Oversight Committee. This committee will then determine if further action is necessary.

In the event CCP is made aware of an issue where a member is not demonstrating the responsibilities as outlined above, CCP will make good faith efforts to address the issue with the member and educate them on their responsibilities.

Member Rights

A member has the right to:

- Be treated with courtesy and respect, with an appreciation of his or her individual dignity, and with the protection of his or her need for privacy.
- Obtain information on available treatment options and alternatives regardless of cost, benefit coverage or condition, presented in a manner that you can understand.
- Know what member support services are available, including whether an interpreter is available if he or she does not speak English or is hearing impaired.
- To get information from CCP in the format or language they need, such as:
    - 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 your Member Rights and Responsibilities
- Know who is providing medical services, who is responsible for his or her care, and the credentials of those providing care.
- Know what rules and regulations apply to his or her conduct.
- Be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information, and necessary counseling on the availability of known financial resources for his or her care. To obtain a copy of your medical records. To make changes or amend your medical records as allowed by law.
- Know, if eligible for Medicare, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- Express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health plan.
- To file an appeal through the plan's grievance and appeals process about the services provided by the plan or one of the plan's providers.
- To exercise their rights and not have it affect the way you are treated.
- To make suggestions regarding the plans Members Rights and Responsibilities policy.

Member Responsibilities

CCP members, their families, or guardians are responsible for:

- Reporting unexpected changes in his or her condition to the health care provider. To listen and work with your health care provider. To give your health care provider the appropriate medical information they need for your care.
- Reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- His or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- Assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- Following health care facility rules and regulations affecting member care and conduct.
- Understanding member rights under the Rehabilitation Act of 1973.
- Calling Florida KidCare at 1-888-540-5437 if he or she has an address or telephone number change.
- Reporting to their health plan or to Florida Healthy Kids Corporation if fraud is suspected.

CCP will not impose enrollment fees, premiums, 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.

Member Grievances and Appeals

Grievance and Appeal Department

Federal law requires managed care organizations to have internal grievance and appeal procedures under which members or providers acting as their authorized representatives may challenge a denial of coverage for medical necessity. These procedures must include an opportunity to file a grievance, and/or an appeal. A member's authorized representative, including providers, may file grievances and appeals on the member's behalf with the written consent of the member. CCP will not take punitive action against any provider for filing an appeal, requesting an expedited appeal, or supporting a member's request for an expedited appeal.

Member Grievances

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to:

- the quality of care or services provided
- aspects of interpersonal relationships such as rudeness of a provider or employee
- failure to respect the member's rights regardless of whether remedial action is requested

Grievances also include a member's right to dispute an extension of time proposed by CCP to make an authorized decision.

All grievances will be thoroughly investigated using applicable regulatory and contractual provisions, collecting all pertinent facts from all parties, and applying the plan's written policies and procedures. CCP will also ensure that the appropriate decision-makers with the authority to implement corrective action are involved. The member or their representative will have an opportunity to review the case file, including medical records and any other documents and records upon request.

A member (or provider on behalf of a member) may file a grievance at any time. CCP will send a confirmation letter within five business days, documenting that the grievance has been received and is being reviewed. A standard grievance is completed within 90 days unless extended appropriately.

The standard timeframe for a grievance may be extended by up to 14 days per the member's oral or written request, or if there is a need for additional information. We will provide oral notice of the delay and written notice of the decision to extend the timeframe within two days. If you or the member disagree with the extension, you have the right to file a complaint with the Department of Health and Human Services.

You can assist the member with filing a grievance by contacting our Member Service Department by telephone or in writing, with the member's consent.

To file a grievance, you can:

- Call Member Services at 1-866-930-0944 (Monday - Friday 7:30 a.m. to 7:30 p.m. EST)
- Write us a letter telling us why you are not happy. Be sure to include:
    - The member's first and last name
    - The member's ID number, and
    - The member's address and telephone number.

Mail the letter to:

COMMUNITY CARE PLAN
Attn: Grievance & Appeals Department
1643 Harrison Parkway, Building H, Suite 200
Sunrise, FL 33323

Fax: 954- 251-4848

Email: Grievancesandappeals@ccpcares.org

Member Appeals

A member appeal is a review by CCP of an adverse benefit determination. An appeal may be filed within sixty days of receiving the notice of adverse benefit determination. If an appeal is filed orally (except for an expedited appeal), it must be followed with a written notice within ten days of calling in the appeal. A member may file an appeal, or an authorized representative, including a provider acting on the member's behalf with written consent.

CCP will acknowledge receipt of the appeal in writing within five business days. We will provide a resolution within thirty days unless appropriately extended. Appeals are limited to a single level.

An “expedited” appeal can be requested if the provider or member feels that waiting thirty days for a decision could put the member’s life, health, or ability to attain, maintain, or regain maximum function in danger. This can be done by phone or in writing, but it must be clear that you are requesting an expedited appeal. If your request does not meet the expedited criteria, we will process it under the normal time frames. If we do expedite the appeal, we will advise of the decision within 72 hours after receiving the expedited appeal request.

Individuals making decisions about an appeal:

- Are not involved in any previous level of review or decision-making and are not the subordinate of any such individual;
- Have the appropriate clinical expertise in treating the member’s condition or disease; and
- Accept all comments, documents, records, and other information submitted by the member or the member’s representative into account without regard to whether such information was submitted or considered in the initial adverse benefit determination.

If a member wishes to further appeal CCP’s decision to uphold an appealed decision, they may proceed to the independent external review process.

You can assist the member with filing an appeal by contacting our Member Service Department via telephone or in writing, with the member’s consent.

To file an appeal, you can:

- Call Member Services at 1-866-930-0944 (Monday - Friday 7:30 a.m. to 7:30 p.m. EST)
- Write us a letter telling us why you are appealing. Be sure to include:
    - The member’s first and last name;
    - The member’s ID number; and
    - The member’s address and telephone number.

Mail the letter to:

COMMUNITY CARE PLAN
Attn: Grievance & Appeals Department
1643 Harrison Parkway, Building H, Suite 200
Sunrise, FL 33323

Fax: 954- 251-4848

Email: Grievancesandappeals@ccpcares.org

INDEPENDENT EXTERNAL REVIEW

Members may request an independent external review within 120 days of notification that an appealed adverse benefit determination has been upheld or when the appeal process has been deemed exhausted by way of CCP’s failure to adhere to the notification and timing requirements. You will receive a written response within 45 calendar days from the date your external review request is received.

You can assist the member with filing an independent external review by contacting our Member Service Department via telephone or in writing, with the member’s consent.

To file a grievance, you can:

- Call Member Services at 1-866-930-0944 (Monday - Friday 7:30 a.m. to 7:30 p.m. EST)
- Write us a letter telling us why you are requesting the external review. Be sure to include:
    - The member's first and last name;
    - The member's ID number; and
    - The member's address and telephone number.

Mail the letter to:

COMMUNITY CARE PLAN
Attn: Grievance & Appeals Department
1643 Harrison Parkway, Building H, Suite 200
Sunrise, FL 33323

Fax: 954- 251-4848

Email: Grievancesandappeals@ccpcares.org

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 Operations Department. Providers are notified 45 days prior to any changes.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. Providers who are registered to use PlanLink are asked to use the Web Portal when requesting prior authorization of medical services. Until PlanLink access has been granted, providers may in the interim, fax the request to CCP Utilization Management (UM) Department at 1-866-930-0969. The CCP Florida Healthy Kids PA Request Form can be found on our website (www.CCPHealthyKids.org) under Providers for Florida Healthy Kids – Services Requiring Prior Authorization. Turnaround times for authorization of requested services are as follows:

- Expedited requests will not exceed three calendar days.
- Standard requests will not exceed 14 calendar days.
- Retrospective / Post Service requests will not exceed 30 calendar days.
- The time frame for authorization decisions can be extended up to four additional days for a standard request and one day for an expedited request if the member or provider requests an extension; or
- If CCP justifies the need for additional information and how the extension is in the member's interest. For these cases, an extension letter request will be mailed to the member, requesting provider, and will be saved in the clinical documentation system.

CCP has adopted utilization review criteria developed by Change Healthcare InterQual Products and other nationally recognized criteria. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, considering 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 a member or practitioner/provider calls the CCP Member Services Department regarding the UM process and authorization of care, Member Services will triage the call and warm transfer the call to a UM nurse as needed. When addressing these calls, the UM staff will identify themselves by name, title, and organization name.

Providers can request a copy of UM criteria by contacting Member Services 1-866-930-0944.

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 are still not met, the request will be forwarded to the Medical Director for review and determination. Practitioners can 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** section.

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

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

- Decision-making at CCP is based ONLY on the appropriateness of care and service, and the existence of coverage.
- CCP 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 FOLLOWING LIST OF SERVICES THAT REQUIRE PRIOR AUTHORIZATION. AUTHORIZATIONS ARE VALID UP TO 60 DAYS UNLESS OTHERWISE INDICATED AT THE TIME THE AUTHORIZATION IS ISSUED.

Services Requiring Prior Authorization

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

ccpcares.org/Providers/FloridaHealthyKids/ServicesRequiringPriorAuthorization

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

Prior Authorization for New Members to CCP

For both voluntary and assigned members, written documentation of prior authorization of ongoing services will be honored for up to 60 days after the effective date of enrollment in CCP or until the PCP reviews the member's treatment plan, whichever comes first. Services need to have been pre-arranged prior to enrollment in CCP, including:

- Prior existing orders (including Home Health and Durable Medical Equipment)
- Prior appointments, surgeries
- 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 PCP of the encounter to expedite follow-up care. The member 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.

Scope of Service

Emergency services will be provided to all members in accordance with State and Federal laws. 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 UM Department is notified of the emergency room visit, the PCP will also be notified via fax or telephone in order to initiate appropriate follow-up care.

Members 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

Behavioral Health Services

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

It is the responsibility of CCP 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 CCP 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.

Member Self-Referral

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

Telemedicine Coverage Provisions

CCP utilize telemedicine for covered services, as follows:

- Telemedicine services 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 member 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 has completed the training regarding the telemedicine requirements in this Contract.

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

- CCP 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 member has a choice of whether to access services through a face-to-face or telemedicine encounter.
- CCP, 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:
- Telephone conversations, chart reviews, electronic mail messages, or facsimile transmissions
- Equipment required to provide telemedicine services

CCP includes procedures specific to the 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.

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
- ONGOING 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 representatives from Behavioral Health, 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 asthma, diabetes, and obesity 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 effectively and efficiently maintain the promotion and delivery of high-quality physical and behavioral health care 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.

QUALITY MANAGEMENT

To improve the quality of care to our members within a managed care system of delivery, provide a high standard of health care and education, improve the health status of the community, and have satisfied members and providers, a comprehensive Quality Improvement Program has been developed. An explanation of monitoring methodologies, along with benchmarks and performance targets can be obtained from CCP's Quality Department. CCP retains the right to use practitioner- and provider-performance data for Quality Improvement activities.

The medical services your practice provides will determine which of the following quality indicators will be assessed, including:

Well Child\Other Preventive Care

ITEM	CODE
Immunization for Adolescent Combo 2	IMA
Follow-up Care for Children Prescribed ADHD Medication	ADD
Weight Assessment and Counseling for Nutrition and Physical Activity for Children\Adolescents	WCC

Adult Preventive Care

ITEM	CODE
Chlamydia Screening for Women ages 16-18	CHL

Other Chronic and Acute Care, including Comprehensive Diabetes Care

ITEM	CODE
Comprehensive Diabetes Care (with BP)	CDC
Controlling Blood Pressure	CBP
Medication Management for People with Asthma	MMA

Pregnancy-Related Care

ITEM	CODE
Prenatal and Postpartum Care	PPC

Mental Health

ITEM	CODE
F/U After Hospitalization for Mental Illness	FUH
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.

Member Availability/Accessibility to Services

CCP providers are required to meet the following access to care standards:

- Emergency Medical Care - available 24 hours a day, 7 days a week
- Urgent Care—within one day
- Routine Sick Care—within 7 days
- Well Care—within 4 weeks
- Follow up Care – as medically appropriate

Scope of Quality Monitoring Program

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 a review of the demographic and epidemiological distribution of members
- Review of acute and chronic care services
- Continuity and coordination of care
- Over- and under-utilization of medical resources
- Provider and member satisfaction surveys
- Complaint and grievance monitoring and analysis
- Compliance with practice guidelines including preventive health guidelines

After-Hours Availability/Call Coverage

Access to the PCP or licensed clinician must be 24 hours a day, 7 days a week. After-hours access must be with someone who is licensed to render a clinical decision and 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. 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
d. Evidence of the provider's professional liability claims history (National Providers Data Bank (NPDB) and Office of the Inspection General (OIG)
e. Any sanctions imposed on the provider by Medicare and Medicaid or any Licensing Agency

f. Evidence of specialty board certification(s), if applicable
    1. 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.
    2. 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 fingerprints electronically but shall document the results of the previous screening.
    3. 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.
g. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106)
h. 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 Florida Healthy Kids Corporation, 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 UM practices. Providers and provider staff will be required to provide proof of licensure, certifications and professional qualifications including continuing education commensurate with job requirements. Providers must send updated documentation of license to practice, DEA (if applicable), board certification, and malpractice insurance upon renewal.

Medical Records Documentation Standards

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

- Each record must contain identifying information on the member, including name, member identification number, 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 diagnoses 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).
- Each record must be legible and maintained in detail.
- Each record must contain an immunization history.
- Each record must contain information on the use of tobacco, alcohol, and drugs/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 member and translation needs of the member.
- All records must identify members needing communication assistance in the delivery of health care services.
- All entries in each record must be dated and signed by an appropriate party.
- All entries in each record must indicate the chief complaint or purpose of the visit, the objective findings of the 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 the 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 the completed screenings is included in the member record and is provided to the member.
- Records must contain a copy of any express written and informed consent of the member's authorized representative or attestation form(s) used by CCP or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13) years. This includes antipsychotics, antidepressants, antianxiety medications, and mood stabilizers.
- 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 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 member was provided written information concerning the member's rights regarding advanced directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether the member has executed an advance directive. The provider shall not, as a condition of treatment, require the member 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 member (ages 18 and older including emancipated minors / for members under 18 or not emancipated – documentation of offered/discussion with parent/guardian).
- All records must contain an HRA Form when one is returned by the member and sent to the provider. This includes documentation of preterm delivery risk assessment by week 28 of pregnancy.
- All records must contain documentation of significant findings and medical advice given to the member in person, by telephone, online or provided after-hours.
- Records of members 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 member or the member'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 special needs (e.g., safety, sanitation, need for physical adaptations, the general condition of the home, amount of space, adequacy of the sleeping area, access to the bathroom, temperature, availability of food, etc.).
- Documentation of missed or canceled appointments and subsequent follow-up.

Peer Review

It is the intent and purpose of CCP to continually improve the quality of the level of care and service provided to a CCP member. The methodology to achieve this goal is based on establishing standards and performance goals for the delivery of care, services measuring performance outcomes and making 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. Member satisfaction surveys, complaint and grievance monitoring and analysis, and finally, compliance with DM program guidelines are reviewed along with the other standards previously mentioned and are used to access the performance of all PCPs, including Family Physicians, Internists, General Practitioners, Pediatricians, Obstetrician/Gynecologists and Advance Registered Nurse Practitioners (ARNP).

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

- Review of credentialing and re-credentialing applications
- Following CCP's standards for availability and maintenance of medical records
- Preventive care guideline compliance
- Member access to services
- Member grievances
- Quality of care and services
- 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 members, to the transfer of members 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 revoked or suspended license/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 the CCP network either on a temporary or on a permanent basis.

AHCA 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.

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 complications 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 a 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.**
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 a 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 a 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

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 a 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 the CCP Risk Management Program. CCP developed and implemented an incident reporting system to minimize injury/incidents to our members, 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 healthcare 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 the following:

a. Death
b. Brain or spinal damage
c. Permanent disfigurement
d. Elopments
e. Fracture or dislocation of bones or joints
f. Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
g. Any condition requiring surgical intervention to correct or control.
    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 member's diagnosis or medical condition
    2. Required surgical repair of damage resulting to a member from a planned surgical procedure where the damage was not a recognized specific risk, as disclosed to the member and documented through the informed-consent process
    3. A procedure to remove unplanned foreign objects remaining from a surgical procedure.
h. Any condition that required the transfer of the member, within or outside the facility, to a unit providing a more acute level of care due to the Adverse Incident, rather than the member's condition prior to the Adverse incident.

If an **Adverse Incident** occurs to a member, the provider must report the incident, as required by the Agency of Healthcare Administration, to CCP's Risk Manager within **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 days of report and/or request or upon 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.

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 witnesses, 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 refer to the Adverse Incident Form located in the **Forms** section of this manual).*

PLEASE NOTE: Incident Reports are part of risk management files only and copies of Incident Reports must be maintained separately from the member'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.

FORMS

- Claim Reconsideration Form
- Electronic Funds Transfer Request Form
- Pharmacy Prior Authorization Request Form
- Service Request Prior Authorization Request Form
- Potential Quality Issue Referral Form
- PlanLink, our Provider Portal: please visit the Providers section of our CCP website to learn how to get access to PlanLink.

Community Care Plan
The Health Plan with a Heart

REQUEST FOR RECONSIDERATION

1. This form helps communicate your exact request in order to provide better service for you. **Submit legible copies of CMS 1500 or UB04 claim form.**
2. Check the most appropriate box below for type of review requested.
3. **Use only one form per reconsideration request.**

Date: _____

Original Claim#_____

Contact Person _____

Phone Number _____

Mail to:
Community Care Plan
Attention: Claims Review
P.O. Box 841209
Pembroke Pines, FL 33084

Users with PlanLink Access may submit appeals electronically via https://epiclink.mhs.net/

The following fields are required or request for reconsideration will be returned.

☐ **MMCP/ MCHP**
☐ **PCC/UPFUND**
☐ **CCP/ MMA (Medicaid MMA)**
☐ **CCP/CCP HSA (Employee Plans)**
☐ **PPUC**
☐ **HCDPBC / Palm Beach**
☐ **FHK (Healthy Kids)**

MEMBER NAME

First: _____ DOB: _____

Last: _____

MEMBER I.D. NUMBER

Authorization Denials:
☐ Claim denied for "no auth" but services do not require an authorization.
☐ Services were authorized, please review this auth number: _____
☐ Specific services were not authorized, but were medically necessary -
See enclosed supporting documentation & reconsideration letter describing the situation.

Other Denials:
☐ Member Not Eligible on DOS
☐ Untimely filing – see proof attached
☐ Invoice Requested – see attached
☐ COB Information Requested – see attached
☐ Records Requested – see enclosed records
☐ BUND/CMPD – records attached to substantiate procedure(s) for reconsideration

Provider Corrected Claim
☐ Units
☐ Coding (DX/CPT/HCPCS/RevCode/POS)
_____

OTHER: Please Describe
_____
_____
_____

Corrected Claim (Plan Data Entry Error)
☐ Units Paid Incorrectly
☐ Service Code Missing / Paid Incorrectly
☐ Payment Sent to Wrong Address
☐ Payment Made to Wrong Provider

Community Care Plan
The Health Plan with a Heart

Electronic Funds Transfer Request Form

Payee (Vendor) Information

***Name:** _____ ***Tax ID/SSN #:** _____

***Address:** _____

_____ **** Required Field***

***City/ST/ Zip:** _____ _____ _____

***Contact:** _____ ***Phone: ( )** _____

***E-mail:** _____ **Fax: ( )** _____

Financial Institution Information

(All submissions must include this form, filled out in its entirety, AND a voided check in order to be processed. Estimated turnaround time for completed submissions is 45 calendar days. Please submit via email to: EFTforms@ccpcares.org)

**** Please notify the Finance Department via the above email if this information changes ****

***Bank Name:** _____

***Bank Address:** _____

***City/ST/Zip:** _____ _____ _____

ABA/ROUTING NUMBER

ACCOUNT NUMBER

***Company Authorization for EFT/Wire Transfer**

_____ *Authorized Signature*

_____ *Printed Name*

_____ *Title*

_____ *Date*

Internal Use Only

Verified by Finance: _____ Date: _____

Initiated by: _____ Date: _____

Vendor updated by: _____ Date: _____

Community Care Plan
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HealthyKids
a Florida KidCare partner

Prior Authorization Form for Prescription Drug Benefits

If you have questions about our prior authorization requirements for prescription drug benefits, please call 800-424-7906

All of the applicable information and documentation is required. Incomplete forms will be returned for additional information.

1. PRIORITY:

[ ]	a. Standard	
[ ]	b. Date of Service	Services scheduled for this date:
[ ]	c. Urgent	Provider certifies that applying the standard review time frame may seriously jeopardize the life or health of the member

2. PATIENT INFORMATION:

a. Name (First):	b. Last:	c. MI:	d. DOB(mm/dd/yyyy):
e. Gender: [ ] Male [ ] Female	f. Height:	g. Weight:	
h. Address:	i. City, State, Zip:	j. Phone:	
k. Health Plan ID #:	l. Group #:		

3. ORDERING PHYSICIAN/CLINIC INFORMATION:

a. Name:	b. TIN/NPI#:	c. Specialty:	d. Contact Name:
e. Clinic Name:		f. Clinic Address:	
g. City, State, Zip:		h. Phone:	i. Fax or email:

4. RENDERING PHYSICIAN/CLINIC/FACILITY/PHARMACY INFORMATION: **[ ]** Check if same as 3.

a. Name:	b. TIN/NPI#:	c. Specialty:	d. Contact Name:
e. Physician/Clinic/Facility/Pharmacy Name:		f. Address:	
g. City, State, Zip:		h. Phone:	i. Fax or email:

5. REQUESTED MEDICAL PROCEDURE/COURSE OF TREATMENT/DEVICE INFORMATION:

a. Service Type:
b. Setting/CMS POS Code: Outpatient [ ] Inpatient [ ] Home [ ] Office [ ] *Other [ ]
c. *Please specify if other:

6. HCPCS/CPT/CDT CODES

a. Latest ICD Code	b. HCPCS/CPT/CDT Code	c. Code Description	d. Medical Reason

Fax or mail completed forms to:
Community Care Plan
c/o Magellan Rx Management
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 800-424-7906
Fax: 866-291-3728
Website: healthykids.magellanrx.com

Magellan Rx MANAGEMENT℠

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Other Clinical Information – Include/attach clinical/office notes, laboratory information, imaging reports, and any guiding documentation to support medical necessity. If this is an out-of-network request, please provide an explanation.

7. OTHER SERVICES (SEE INSTRUCTIONS)

a. Type of Service:	b. Name of Therapy/Agency:	
c. Units/Volume/Visits Requested:	d. Frequency/Length of Time Needed:	e. Initial [ ] Extension [ ] Previous Authorization #:
f. Additional Comments:		

8. PRESCRIPTION DRUG

a. Diagnosis name and code:			
b. Medication Requested	c. Strength	d. Dosing Schedule (including length of therapy)	e. Quantity Per Month or Quantity Limits
f. Is the patient currently treated with requested medication(s): [ ] Yes [ ] No If yes, When was treatment with the requested medication started?			
g. Explain the medical reasons for the requested medications, including an explanation for selecting these medications over alternatives:			
h. List any other medications patient will use in combination with requested medication:			

9. PREVIOUS SERVICES/THERAPY (INCLUDING DRUG, DOSE, DURATION, AND REASON FOR DISCONTINUING PREVIOUS THERAPY)

a.	Date Discontinued
b.	Date Discontinued
c.	Date Discontinued

Additional Information – Please attach and submit any progress notes, lab data, discharge summaries, or other guiding documentation to support discontinuation of previous therapy and initiation of therapy with the requested medication along with a copy of the prescription.

10. ATTESTATION

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Provider Signature:_____ Date:_____

DO NOT WRITE BELOW THIS LINE: FIELDS TO BE COMPLETED BY PLAN

Authorization #_____ Contact Name: _____

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Instructions for OIR-B2-2180

1. Priority: Only one of the following options should be marked.
    a. Standard should be marked if the prior authorization request is not an urgent request or the medical service has not been scheduled.
    b. Date of Service should be chosen if the requested medical service has been scheduled for a future date. The scheduled date should be written in the corresponding box to the right of the Date of Service label. Note that this is for informational purposes only and that the health insurance issuer is not obligated to provide authorization prior to the scheduled date.
    c. Urgent should be marked if the patient's life may be seriously jeopardized by applying the standard review time frame.
2. Patient Information: All boxes should be completed.
    a. Fill in the patient's first name
    b. Fill in the patient's last name
    c. Fill in the patient's middle initial.
    d. Fill in the patient's date of birth beginning with the two-digit numerical representation for the month, followed by the two-digit numerical representation for the day, followed by the four digit year.
    e. Check the patient's applicable gender.
    f. Fill in the patient's height in inches.
    g. Fill in the patient's weight in pounds.
    h. Fill in the patient's current address if available.
    i. Fill in city, state, and zip code of the patient's address if available.
    j. Fill in the patient's phone number if available.
    k. Fill in the patient's unique health plan identification number.
    l. If available, fill in the patient's group identification number.
3. Ordering Physician or Clinic Information. In this section, complete all of the applicable boxes for the physician who is requesting the medical service.
    a. Fill in the provider's unique tax identification number or national provider identification number.
4. Rendering Physician. In this section, complete all of the applicable boxes for the physician who is being requested to perform or administer the medical service. If the ordering physician is the same as the rendering physician, mark the box next to the title. The section will not need to be completed unless any information differs from section 3.
    a. Fill in the provider's unique tax identification number or national provider identification number.

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Website: healthykids.magellanrx.com

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5. Requested medical Procedure, Course of Treatment, or medical Device information.
    a. In this box, explain with sufficient accuracy the nature of the requested medical service.
    b. Write the Setting or CMS Place of Service Code. Additionally, mark the box to the right of where the requested medical service will be performed or given.
    c. If Other was marked in 5.a., write where the requested medical service or device will be given.
6. HCPCS/CPT/CDT CODES. In this section you should explain the CMS Healthcare Common Procedure Coding System Code, Current Procedural Terminology Code, and or the Current Dental Terminology Code, whichever are applicable and necessary to determine which medical services or procedures are being requested.
    a. Enter the most current International Classification of Disease Code used to classify and code the diagnoses, symptom, or procedure applicable to the patient's condition.
    b. Explain the CMS Healthcare Common Procedure Coding System Code, Current Procedural Terminology Code, and or the Current Dental Terminology Code, whichever are applicable and necessary to determine which medical services or procedures are being requested.
    c. Provide a description of the code used in 6.b.
    d. Provide a medical reason for requesting the medical service.
    Other Clinical Information – If necessary attach other relevant guiding documentation to the request. This does not call for the submission of all documents, just those necessary to make a decision on the request. If this is an out of network request, provide an explanation and attach it to the request.
7. This section should be completed in the event the requested medical service does not fall within the other sections. A description of the nature of the medical service requested and corresponding details should be completed to fully convey what is being requested. Examples of other services may include, but are not limited to, rehabilitation services and home health care services.
8. This section should be completed if prescription medication is being requested.
    a. Fill in the diagnosis name and code of the condition the prescription drug will be used to treat.
    b. Detail the medication requested.
    c. Detail the strength of the medication requested.
    d. Detail the dosing schedule of the medication requested, including the length of therapy.
    e. Detail the quantity per month or quantity limit of the medication requested.
    f. Check the appropriate box and explain if necessary.
9. Previous Services or Therapy (Including Drug, Dose, Duration, and Reason for Discontinuing Previous Therapy). This section should be completed if the patient has had previous therapy relating to the medical service being requested. All relevant previous services or therapy should be explained. If there is not enough space, attach another sheet to explain other therapies. If additional guiding documentation is necessary to explain the previous therapy or treatment, that should be attached as well. Include any reason for discontinuing the previous services or therapy.
10. The requesting provider must truthfully certify that all information provided as part of the prior authorization request is true and accurate.

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Community Care Plan
The Health Plan with a Heart

Claims Payor ID FHKC1

Phone number: 1-866-930—0944

PRIOR AUTHORIZATION REQUEST FORM:
COMMUNITY CARE PLAN - FLORIDA HEALTHY KIDS
Fax: 1- 866-930-0969
Participating Providers must submit prior authorization requests for services via Epic Link/ Plan Link web portal. All services rendered by non-participating Providers require authorization.
Prior Auth list and other information available at **www.ccpcares.org**

Priority: ☐ **EXPEDITED** (With complete information, review may take up to 72 hours). Provider certifies that applying the standard review time frame may seriously jeopardize the life or health of the enrollee.

☐ **STANDARD** (With complete information, review may take up to 14 calendar days)

Incomplete requests will not be accepted | Include pertinent clinical documents to facilitate review| If Out of Network, provide explanation

ENROLLEE INFORMATION			
Enrollee Name: (First) (MI) (Last)	DOB (mm/dd/yyyy)	Height/ Weight	Gender
Enrollee ID #	Enrollee Phone #:		
Enrollee Address:	Other payer info: (Medicare, Commercial plan, Dental plan)		
REQUESTING PROVIDER INFORMATION (check one)	☐ **PCP** ☐ **Specialist**		
Office Contact Name:	Specialty:		
Office/ Clinic/ Practice Name:	Address:		
TIN/ NPI#/ FL Medicaid #			
Requesting Provider's Name:	Phone #:	Fax #:	
Requesting Provider's Signature: I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.	Date:		
REFERRED TO PROVIDER INFORMATION (check one)	☐ **In-Network** ☐ **Out-of-Network**		
Provider Name/ Specialty:	Office Contact Name:		
Facility or Practice Name:	TIN/ NPI #	FL Medicaid Provider #	
Address:	Phone #:	Fax #:	
REQUESTED SERVICE TYPE (check one below)	**Date(s) of Service:**		

☐ Ambulatory Surgery Ctr ☐ Behavioral Health/Substance Use Services ☐ Dialysis ☐ Durable Medical Equipment
☐ Hospice Services ☐ Hospital Inpatient ☐ Hospital Observation ☐Hospital Outpatient ☐ Hyperbaric Treatment
☐ Maternity (Procedures) ☐ Out of Network Services ☐ Prosthetic/Orthotic Devices ☐ Respiratory Therapy Services
☐ Skilled Nursing Facility ☐ Transplant Related Services
☐ Other (please specify)_____

ICD-10 Code(s) and description

CPT Code(s) / J Codes/ HCPCS/ units or visits requested and description/ medical reason:

Statement to Provider: This authorization is for Medically Necessary Services Only. Payment is contingent on services being authorized, services being a covered benefit, coordination of benefits, and enrollee eligibility at the time of service. Additionally, it is important that a report of the treatment provided, or service(s) recommended be completed on this enrollee and forwarded to the Requesting and Primary Care Provider within 7 days of services.

Community Care Plan
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Potential Quality Issue (PQI) Referral Form

Risk Manager Confidential Fax:
954-251-4161

CONFIDENTIAL—DO NOT COPY (Please type or print clearly)

Section I	**General Information**				
Member Name:				DOB:	
Sex:		Product:	☐ MMA ☐ FHK ☐	ID#:	
Provider:				Provider #:	
Referred By:				Date:	
Dept./Office:				Phone:	
Section II	**QI Department Only**				
Received By:			Date Received:		
Area Office:			Date Forwarded to		

Section III	**GOSI** ***(Deliver Report to Quality Dept. within 5 days)***
☐	Unexpected admissions or complication of admission due to delay or quality issue regarding outpatient management
☐	Unexpected Readmission within 30 days (post-op complication or same diagnosis, not cancer or hospice)
	Readmission Diagnosis:
☐	Delay in access: ☐ PCP ☐ Specialist ☐ Treatment
☐	Primary cancers advanced: ☐ Breast ☐ Colon ☐Cervical ☐ Prostate
☐	Obstetrical (OB) Complication
☐	Delay or Missed Diagnosis
☐	Other

Section IV	**Adverse Incident** ***(Report to Risk Management within 24 hours)***
☐ Unexpected Enrollee Death	☐ Permanent Disfigurement
☐ Enrollee Brain damage or Spinal damage	☐ Fracture or dislocation of bones or joints
☐ Enrollee Elopement	☐ Any condition that extends the patient's length of stay
☐ Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's pre-existing physical condition.	☐ Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility
☐ Any condition that required transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to an adverse incident	☐ Any condition requiring surgical intervention to correct or control (i.e. foreign body, return to surgery)

Date faxed to Risk Management:

Sender - Print Name: Signature:

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The Health Plan with a Heart

Potential Quality Issue (PQI) Referral Form

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CONFIDENTIAL—DO NOT COPY (Please type or print clearly)

Section V	**Occurrence Information**		
Member Name:		**Member ID**:	
Date of Occurrence:		**GOSI Code #:**	
Description of Occurrence:			

Medical Director Only		
Level Assigned*:	☐ Level I ☐ Level II ☐ Level III	Date Reviewed:
Recommendation:		

MD/DO Signature: **Print Name:** **Date:**

*** Legend:**	Level 1- Acceptable Medical Care Provided, No Further Review Needed Level 2- Opportunity for Improvement in Medical Care Provided Level 3- Medical Care Falls below the Standard of Medical Practice

Section VII	**Risk Management**	Referred Date:	

Risk Manager Evaluation:

Actions: ☐ None Required ☐ Legal/Adm. ☐ CAP ☐ Other:

Signature:	Print:	Date Closed: