Provider Manual

FLORIDA
COMPLETE CARE
Care *you need.*
Compassion you deserve.

Welcome Letter

A Message from our CEO

Welcome aboard! Florida Complete Care (FC2) would like to thank you for choosing to partner with our plan. Florida Complete Care is a new Medicare Advantage Institutional Special Needs Plan (I-SNP) and Institutional Equivalent Special Needs Plan (IE-SNP).

FC2 has established as a guiding principle, a commitment to partnerships with community-based organizations, providers, and caregivers, to enhance our ability to deliver value-based managed care services, specifically aimed at fostering independence and improving health outcomes. Our mission is to provide high-quality solutions across the health care continuum to aged, blind and disabled dual-eligible beneficiaries in the least restrictive environment; always maintaining focus on our effort to ensure Members have access to the covered services they need. Effective communication is a key component to our mutual success in the fulfillment of our mission for the Member.

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

This Provider Handbook serves as a reference guide. It is one of our multiple methods of communication and is part of the provider training for our I-SNP and IE-SNP programs.

Please review the Provider Handbook carefully to learn more about the plan.

Thank you again.

Nestor J. Plana

Table of Contents

CMO's Tips for using this Handbook

This is your Florida Complete Care (FC2) Provider Handbook. It was designed for you. The Handbook is for physicians, ancillary providers, health service providers, hospitals, and other facilities and providers participating in the Florida Complete Care Network.

We understand that managing Member's health is often complex and can be administratively taxing. This Handbook was developed to aid in your understanding of FC2 requirements; and serves as a resource for answering questions you may have about our networks, products, programs, coding, and claims filing guidelines among other things.

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

This handbook can be found online at www.fc2healthplan.com; can be sent to you electronically by email or a paper copy, at no charge, may be obtained upon request by contacting your Provider's Provider Relations representative or calling 833-FC2-PLAN, then press 2.

Any section of this Handbook may be updated at any time. FC2 will notify providers of updates in a variety of ways, depending upon the nature of the update, including mailings, publications, our provider newsletter, or posting to our website. Please refer to our website at www.fc2healthplan.com to access the most up to date information.

In accordance with FC2's policies and procedures clause of the Participating Provider Agreement, FC2 providers must abide by all applicable provisions contained in this handbook. In the event of any inconsistency between information contained in this Handbook and the agreement(s) between you or your facility, the terms of such Agreement shall govern.

Revisions to this handbook reflect changes made to FC2's policies and procedures. Revisions shall become binding thirty (30) days after the notice is provided by mail or electronic means, or such other period as necessary for FC2 to follow any statutory, regulatory, contractual and/or accreditation requirements. Provider Bulletins that are state-specific may override the policies and procedures in this handbook.

Also, please note that at various times when dealing with FC2, you may be given information concerning Member's status, eligibility for benefits, and/or level of

benefits. FC2 will only issue payment following the applicable benefit plan in the individual's actual eligibility as decided by such benefit plan. Further, the presentation of a Florida Complete Care FC2 identification card neither creates nor serves as definitive verification of any Member's status or eligibility to receive benefits. Please check eligibility prior to rendering services.

To improve efficiency, I strongly encourage you to conduct business with us electronically through our Provider Portal. As a quality improvement organization, it is important to note that we reserve the right to make changes to our website, including, but not limited to the re-arrangement of site within the website, the name of a benefit plan or program, branding or to make changes to the Member identification card, along with changes to utilization management program and to give notice to those changes and effective dates directly on the website. We are obligated to give you notice of such changes to our programs, but those notices will only be messaged via the FC2 website and through email only. Therefore, please make sure that you have a valid email on file with FC2 to receive all applicable notifications.

Thank you for being a participating provider with FC2!

Frank C. Astor, MD, MDA, FACS

Florida Complete Care (FC2)

Florida Complete Care is a Medicare Advantage Institutional Special Needs Plan (I-SNP) and an Institutional Equivalent Special Needs Plan (IE-SNP) ("health plan" or "Plan"). FC2's target population is institutionalized Medicare beneficiaries who reside or expected to reside in a contracted long-term care (LTC) facility for 90 days or longer.

Institutional Special Needs Plan (ISNP)

The eligibility for the I-SNP is determined by the level of care required to manage the patient's condition. The State of Florida Comprehensive Assessment and Review for Long Term Care (CARES) Bureau within the Florida Department of Elder Affairs (DOEA) has established assessment methodologies that are based on research and recognized practice standards. The 701(t) and 701(b) CARES assessments determine if an individual needs institutional level of care.

The FC2 I-SNP Members will be comprised of people living in skilled nursing facilities that have Medicare Parts A and B and have met the 701(t) screening requirements for institutional level of care.

Institutional Equivalent Specials Needs Plan (IESNP)

The eligibility for the IE-SNP is determined similarly as the I-SNP, by the level of care required to manage the patient's condition. The State of Florida Comprehensive Assessment and Review for Long Term Care (CARES) Bureau within the Florida Department of Elder Affairs (DOEA) has established assessment methodologies that are based on research and recognized practice standards. The 701(t) and 701(b) CARES assessments determine if an individual needs institutional level of care.

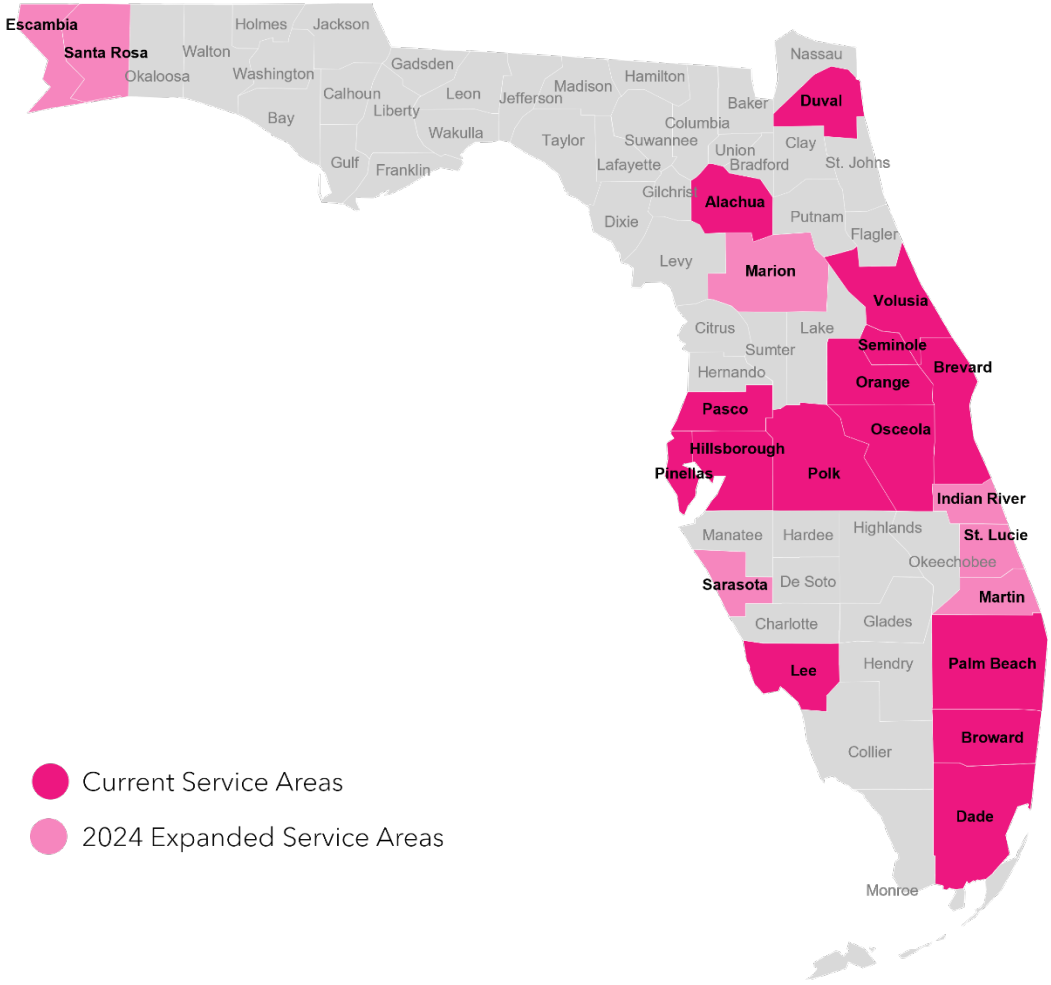
The FC2 IE-SNP plan enrollment will be comprised of people that have Medicare Parts A and B, living in the community, and have met the 701(b) screening requirements for an institutional level of care as determined by State of Florida's Department of Elder Affairs, CARES Bureau.

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

The eligibility for the FIDE SNP is for members who are dual eligible to receive Medicare & Medicaid benefits and are currently enrolled in our Medicaid plan, Florida Community Care (FCC). The target population is specifically FCC members who reside at their home.

Florida Complete Care Service Area

Florida Complete Care's service areas consists of 15 Florida counties highlighted below. For the 2024 Benefits Year, FC2 has expanded to an additional seven counties.



FC2 Model of Care

The FC2 Model of Care (MOC) serves as the fundamental framework that outlines how FC2 will fulfill the healthcare needs of its members.

With an emphasis on preventing avoidable hospitalizations and mitigating acute exacerbations of chronic conditions, the (MOC) is designed to enhance the quality of life for its members. This is achieved through the provision of Medicare-covered services, as well as supplementary benefits that extend additional support and services tailored to the unique needs of FC2's special populations.

The MOC is a vital quality improvement tool and an integral element in ensuring that the distinctive needs of every member are not only recognized by the SNP but also effectively addressed through the FC2's care and utilization management practices. It serves as the cornerstone of care, with the overarching goal of promoting the following:

- Quality of care
- Access to medical, mental health, and social services
- Access to affordable care
- Integration and coordination of care across specialty, multi-setting care continuum through central point of contact
- Seamless transitions between care settings
- Appropriate utilization and cost-effective service delivery
- Member experience and quality of life
- Health outcomes

Integration and Coordination of Care

- FC2 Members are assigned a primary care provider (PCP) that will serve as a gatekeeper and is responsible for identifying the needs of the member
- Members are managed by an interdisciplinary care team (ICT) that works together to review and address the unique and diverse needs of each member.
- Members are assigned a care manager who is responsible for coordinating a continuum of care activities to ensure the member's needs are being met, the optimum utilization of resources as well as to prevent fragmentation of care.
- Seamless transition between care settings including planned or unplanned admission to the hospital, discharge from the hospital, rehab, and skilled nursing facility. The care manager is the central point of contact for all transitions.

FC2 Care Management Program

Within the FC2 integrated Model of Care, FC2 care managers play a pivotal role. The care managers are tasked with assessing members' needs, developing, and implementing comprehensive, person-centered care plans, coordinating care seamlessly across the continuum, and serving as strong advocates for members, ensuring that the member always remains at the heart of the care process.

For the ISNP or ISNP Programs, all members are assigned to a Register Nurse Care Manager (RNCM) who serves as the primary point of contact to the member and the member's healthcare providers.

For the FIDE Program, the care management activities are performed by clinical and non-clinical care managers.

The FC2 care manager conducts a thorough Health Risk Assessment (HRA) to identify the member needs and any gaps in care. FC2 employs the 701B and 701T assessment tools for this purpose. Additionally, supplemental assessments, such as those specific to certain diseases, fall risk, and caregiver adequacy, are conducted when deemed necessary as part of the assessment process. These assessments are completed either in-person or via telephone within 90 days of enrollment and subsequently on an annual basis, or more frequently if there has been a change in the member's health condition.

Risk stratification is generated after the HRA is completed. Member risk assessment also considers claims data, when available, as an integral part of the risk stratification process.

A comprehensive, individualized care plan (ICP) is developed based on the various assessments to include the member's personal healthcare preferences and self-management goals, interventions and services that are specifically tailored to the member's needs. The ICT also contains the roles of family members and caregivers and their preferences for participation in the care planning process.

The Individualized Care Plan (ICP) is shared with the member or their authorized representative, as well as the member's Primary Care Physician (PCP) and the facility where the member resides.

The FC2 Care Manager plays a crucial role in assisting the member with the care coordination of the ICP. Once the ICP is developed, the FC2 care manager takes the lead in coordinating the delivery of medical and long-term care (LTC) benefits in close collaboration with the member's healthcare providers. This collaborative approach ensures seamless continuity of care and the integration of Medicaid and Medicare services. This approach not only reduces administrative complexities but also prevents service duplication through integrated Care Management activities, ultimately improving the overall member experience.

Member Identification Cards

Florida Complete Care Members receive a health care identification (ID) card which is designed to help access the automated phone or online systems to verify benefits, eligibility, and claim status. Each health care ID card includes a unique identifier.

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

Should the Member lose or misplace the ID card, a new one can be obtained by contacting FC2 Member Services at 1-833-FC2-PLAN, Option 1 or requesting same online at [www.fc2healthplan.com.](http://www.fc2healthplan.com)

Collaborating with Florida Complete Care Tools and Resources

Doing business with Florida Complete Care (FC2) is easier and faster than ever when you take advantage of the wealth of information and resources available to you online. Stay up to date on our latest products and programs and process changes by simply accessing bulletins, newsletters, and other valuable resources and tools available on our website.

Provider Communication Tools

When visiting our Provider Portal, take a moment to sign up for the FC2 provider notice system which provides many benefits including:

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

Provider Handbook

This provider handbook shall serve as a source of information regarding Florida Complete Care covered services, procedures, statutes, regulations, telephone access, and special requirements. A copy of the handbook is available online at our website: www.fc2healthplan.com. A hard copy can be requested via phone at no additional cost to you by contacting our Provider Relations Department at 1- 833-FC2-PLAN, Option 2.

Provider Portal

The FC2 Secure Web Portal is a web-based platform that allows FC2 to communicate Member information directly with providers. Providers and their supporting staff can access several functions within this platform including:

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

To access this information, providers must first register for the portal by navigating to www.fc2healthplan.com and clicking on the Provider Portal link. Please see the following pages for more information.

Provider Portal Login Page

FLORIDA COMPLETE CARE

Sign into your account

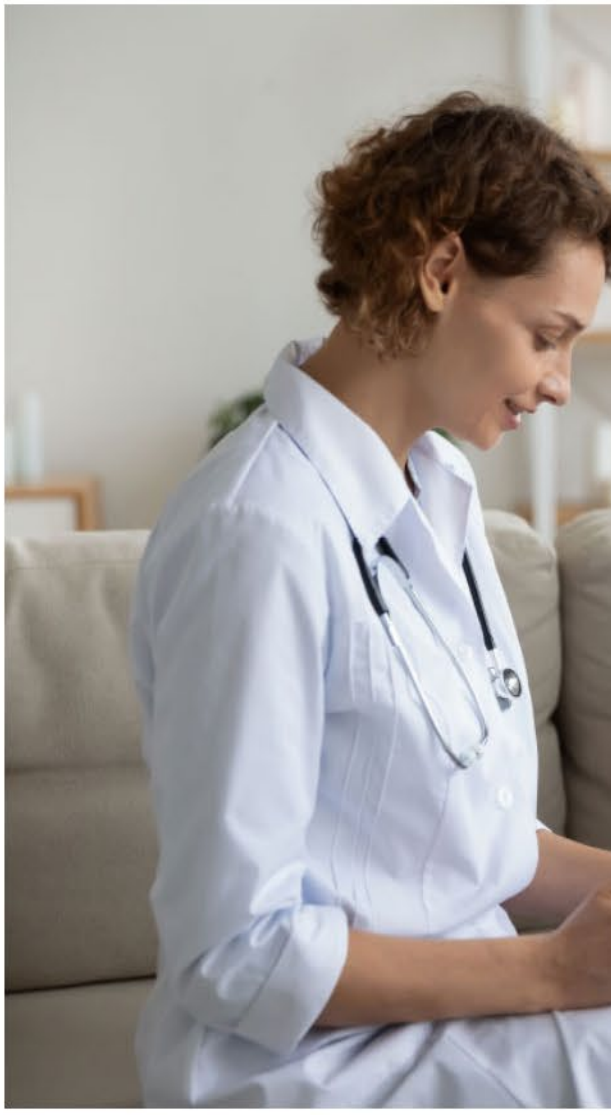
Username

Password

Sign in | Create account

Forgot your username or password?

Join our network



Provider Portal Registration

First Name

Last Name

Practice Name

Department

Contact Name

Contact Phone

Title

Address Line 1

Address Line 2

City

State

-- Select --

Zip

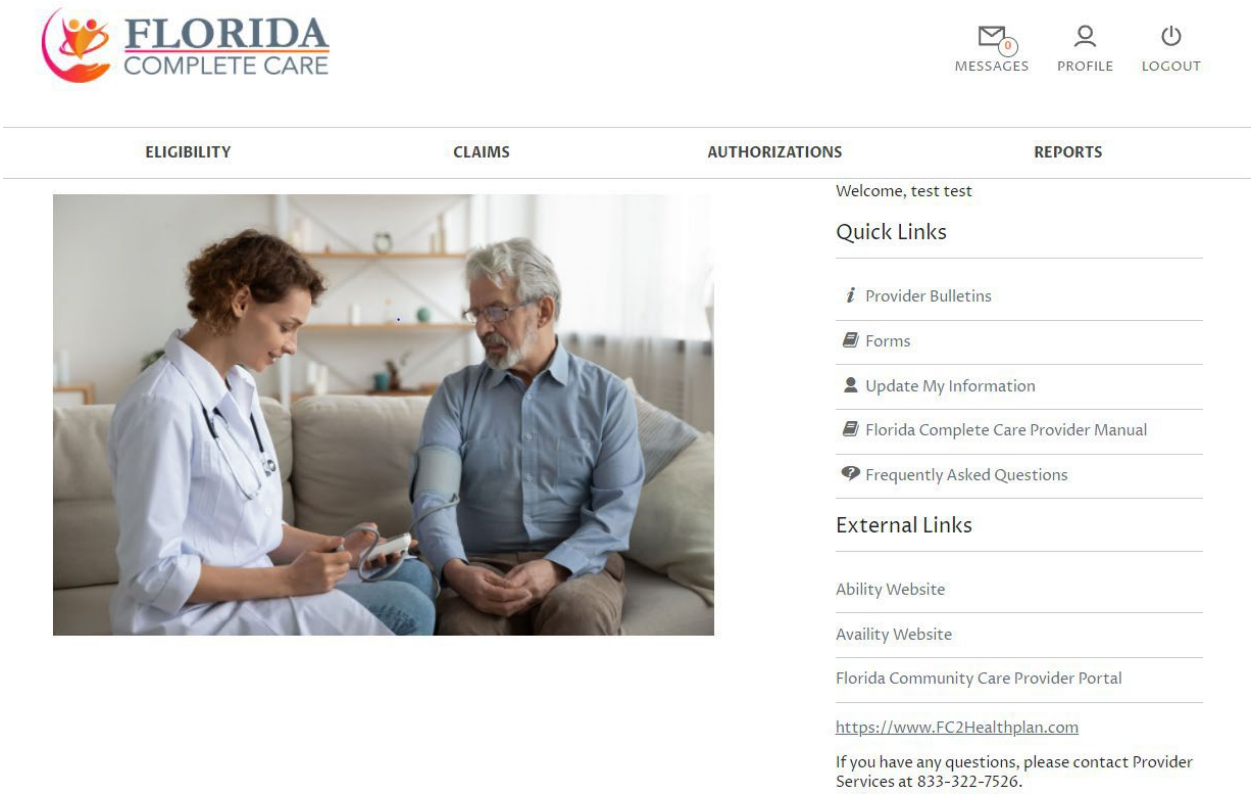
TIN

NPI

Previous | Add Provider | Cancel

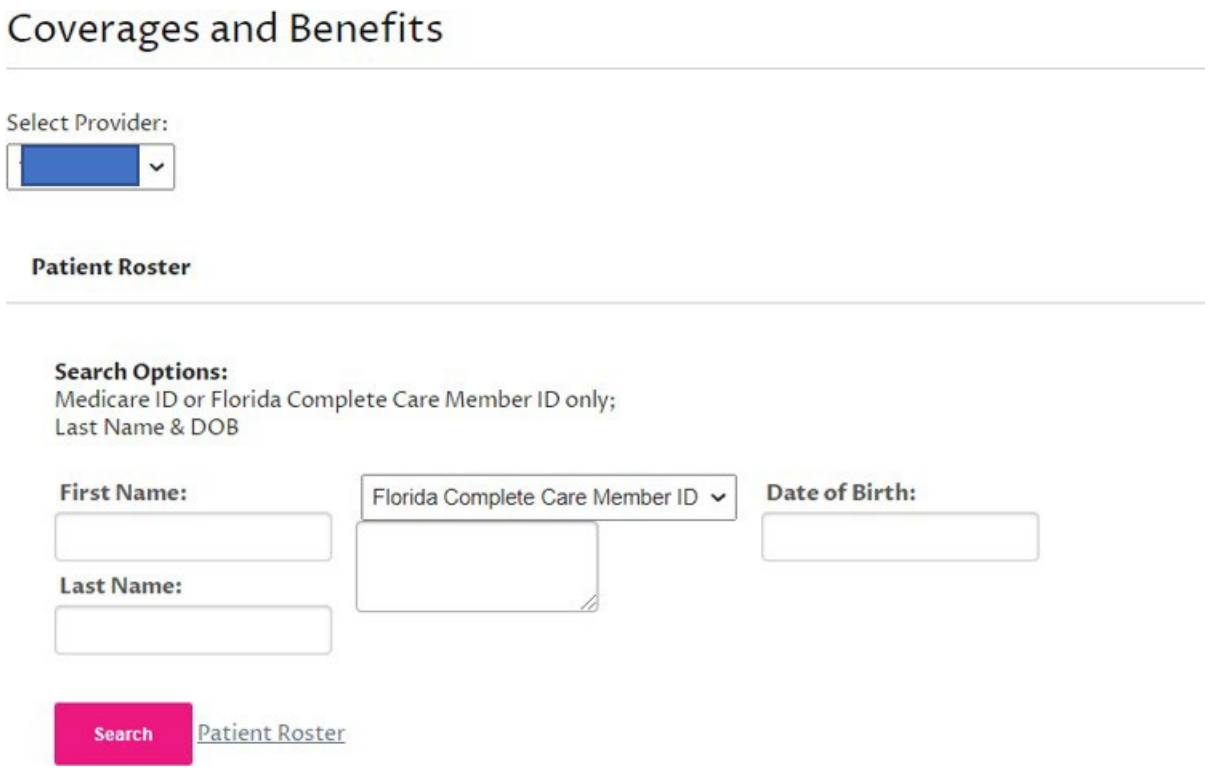
Provider Portal Main Page

Upon logging in, providers may view Eligibility, Claims, Authorizations, or custom reports, as well as view or download important bulletins and documents.



Eligibility Inquiry

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



Eligibility Results – Summary View

Eligibility Results – Detail View

Coverages and Benefits

Current Member: [redacted]

← View Patients

FLORIDA COMPLETE CARE

Subscriber

Member:	[redacted]	**Group Name:**	[redacted]
Member ID:		**Group Number:**	
Status:		**DOB:**	
PCP:		**Termination Date:**	

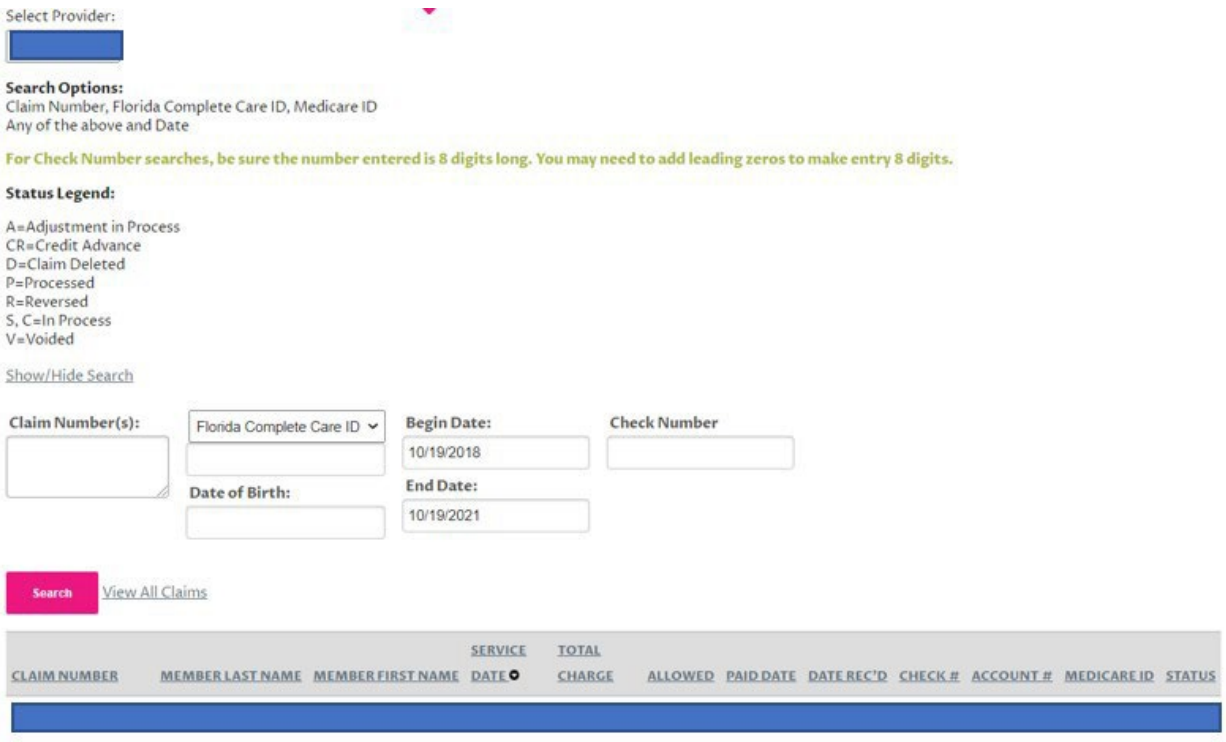
Coverages

[redacted]

Current Benefit Effective Date	04/01/2021	**Termination Date**		**Tier**	INDIVIDUAL
Plan	[redacted]				

Claim Status Inquiry

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



Claim Status Detail

Claim #[redacted]

Date Received:	09/09/2021	**Member:**	[redacted]	**Member ID:**	[redacted]
Provider Name:	[redacted]	**Provider ID:**		**Account Number:**	
Date Paid:		**Check Number:**		**Status:**	
Authorization Number:		**Primary Diagnosis:**			
Reversal Code:		**Reversal Description:**			

Payment Details

Claim Received	Pay To	Amount	Date Paid
09/09/2021	[redacted]	$0.00	

Claim Details

DATE(S) OF SERVICE	PROCEDURE CODE(S)	1ST MODIFIER	POS	NOS	CHARGED	ALLOWED	COPAYMENT	TOTAL AMOUNT PAID	EOB CODE	MESSAGE CODE
08/27/2021	99218		22	1	$1,161.00	$0.00	$0.00	$0.00		
08/27/2021	1123F		22	1	$200.00	$0.00	$0.00	$0.00		
Total Interest								$0.00		
Total Discount								$0.00		
Total					$1,361.00	$0.00	$0.00	$0.00		

Check Summary

DATE PAID	CHECK NUMBER	PAYEE ID	PAYEE NAME	BULK AMOUNT
[redacted]				

Reason Code Descriptions

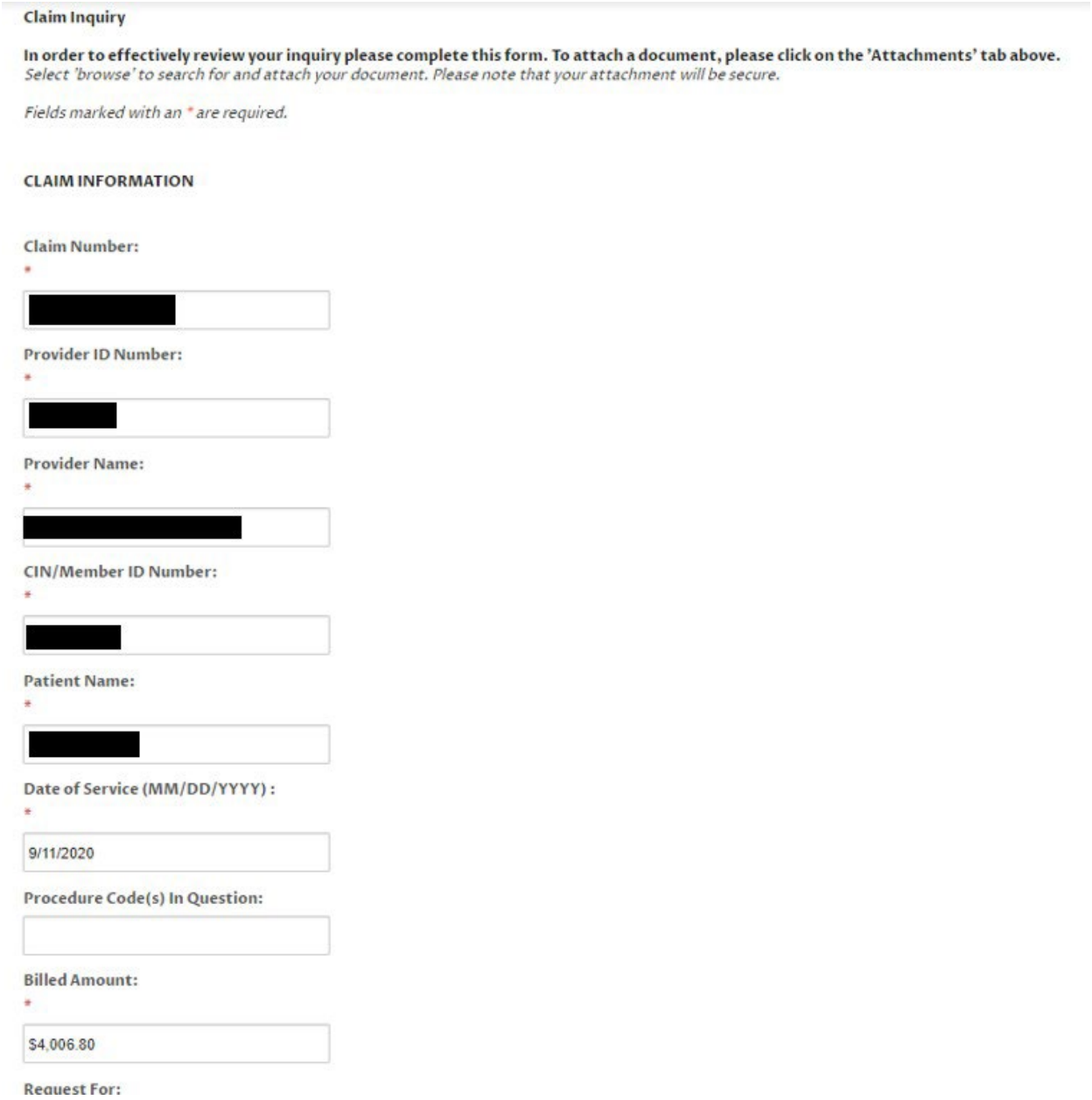
1123F - ACP DISCUSS/DSCN MKR DOCD
99218 - INITIAL OBSERVATION CARE

Disclaimer
THIS IS NOT A BILL
Claim for j[redacted]

Back to Search Results | Print View | EOP Image

Claims Adjustment/Inquiry

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



Claim Inquiry

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

*Fields marked with an * are required.*

CLAIM INFORMATION

Claim Number: *
[redacted]

Provider ID Number: *
[redacted]

Provider Name: *
[redacted]

CIN/Member ID Number: *
[redacted]

Patient Name: *
[redacted]

Date of Service (MM/DD/YYYY) : *
9/11/2020

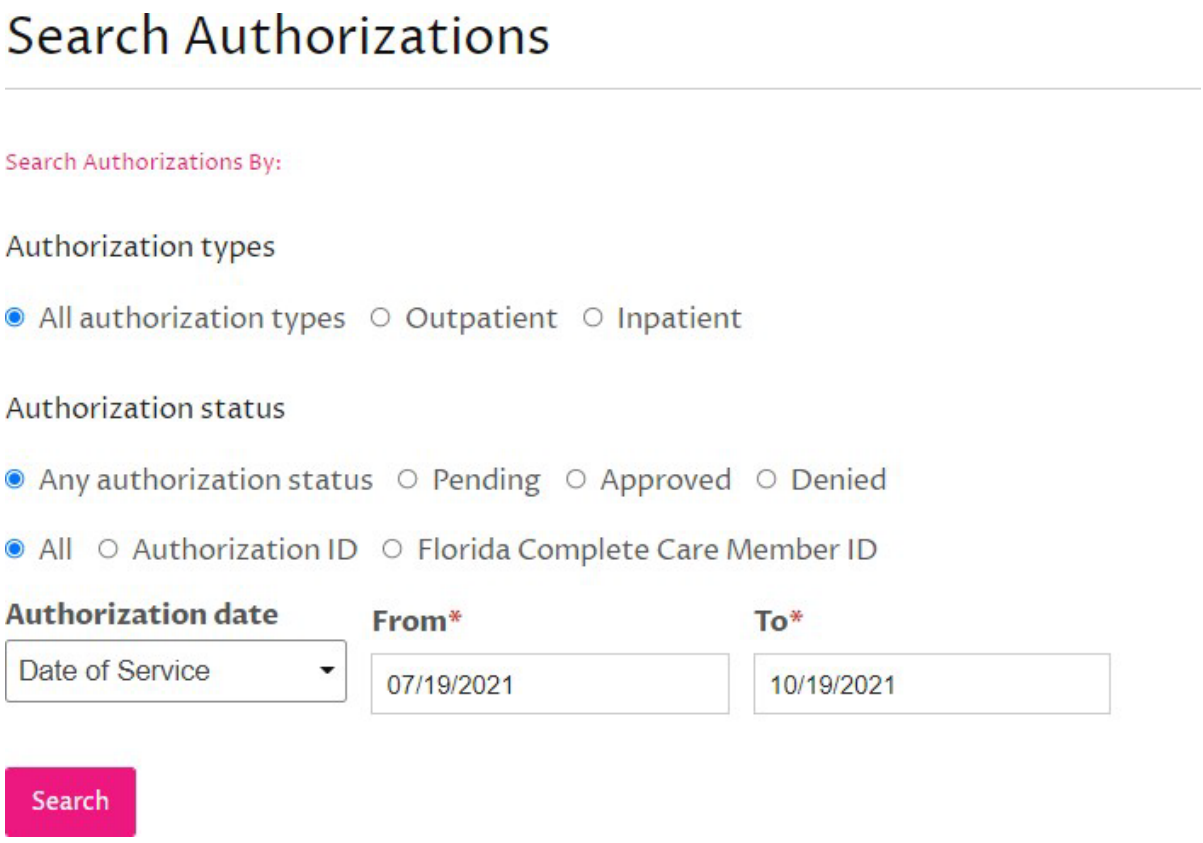
Procedure Code(s) In Question:

Billed Amount: *
$4,006.80

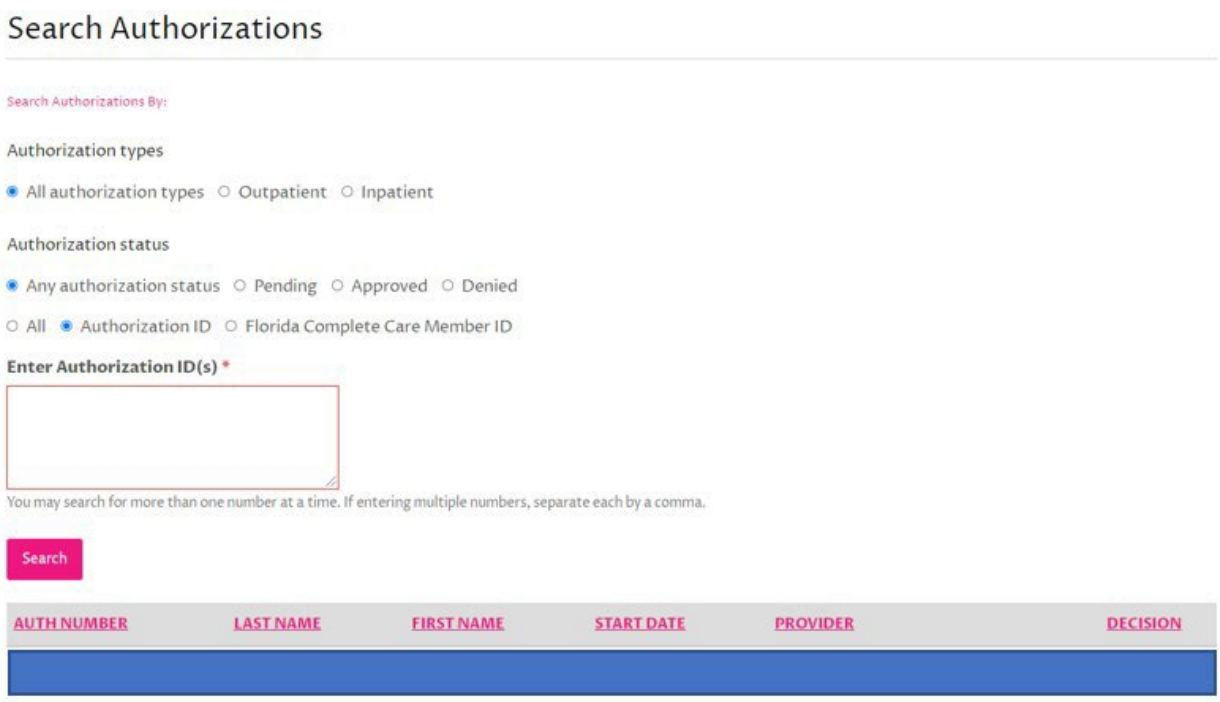
Request For:

Authorization Inquiry

To check authorization status, users should click on the Authorizations link to search for Enrollee's authorizations by entering either enrollee ID or Authorization number. Searches may be narrowed by entering the type of authorization, as well as start and end dates.



Authorization Summary



Print

FLORIDA COMPLETE CARE

Authorization # [redacted]

Authorization #	[redacted]	**Status:**	APPROVED	**Approved Type:**	PXA
Requested Dates of Service:		**Requesting Provider:**	[redacted]	**Servicing Provider:**	[redacted]
Member Name:		**Member ID:**		**Date of Birth:**	9/20/1949
Diagnosis Code:		**Description:**	[redacted]		

Service Details

Status:	APPROVED
Approved Dates of Service:	6/10/2021
Place of Service:	OFFICE

Procedure Code	Description	Status	Mod 1	Mod 2	Mod 3	Mod 4	Approved Units
G0444	ANNUAL DEPRESSION SCREENING 15	APPROVED					1

Providers

Servicing Provider	
Provider:	[redacted]
Phone Number:	
Servicing Provider NPI:	
Address:	

Requesting Provider	
Provider:	[redacted]
Phone:	
Address:	

Provider Training

Training is delivered through a variety of methods such as:

- Webinars and Town Hall Training Sessions
- One-on-one with individual providers
- Written materials – Provider Handbook
- Educational Bulletins
- Notices on our Provider Portal

Training materials are available through the health plan website at www.fc2healthplan.com; or by calling 1-833-322-7526, press 2 and then option 3 for Provider Services and request assistance with Provider Education.

Florida Complete Care's Provider Network

Florida Complete Care (FC2) providers are selected to participate in our network based on an assessment and determination of the network's needs. FC2 providers must be contracted with and credentialed by FC2 or the entity under contract to perform credentialing services. FC2 may agree to delegate credentialing to a provider organization so long as a) a Delegation Agreement is signed by both parties, and b) a delegation audit is conducted and found to be satisfactory.

From time to time, our provider network may be closed or partially open for recruitment of providers in specific service areas, provider types or services. It is important to confirm the provider's network status prior to initiating your request to join our network. Please contact Provider Services at 1-833-FC2-PLAN, Option 2 for more information.

Credentialing with Florida Complete Care

The verification of credentials is an integral part of our on-boarding process. It helps ensure our members have access to quality care and is also required to meet both state and federal guidelines. We currently use the Council for Affordable Quality Healthcare (CAQH) as our preferred method of application data; please ensure that your current CAQH is complete and accurate, and that attestations are complete and current. This will help facilitate the credentialing verification process. Go to www.caqh.org/ucd_physician_faq.php for detailed information on how to create/edit your application with CAQH. Credentialing staff perform the credentialing verification process and will access your CAQH application or contact you regarding completion of a credentialing application if you do not use CAQH. We highly recommend that you consider using CAQH as it will make the credentialing and re-credentialing process much easier.

Ancillary and Facility are not required to use CAQH. These providers must complete and submit a credentialing application. If additional application information is needed from a provider, the FC2 credentialing staff may contact you. Be sure to comply with any response for additional credentialing information timely to ensure the application process is not delayed. We will complete the credentialing and onboarding process within sixty (60) days of the receipt of a complete application.

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

Background Screening

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

Provider Credentialing Requirements

General Credentialing Requirements are as follows:

- Each provider must have an NPI in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The NPI numbers must be submitted to FC2. Entities that do not meet the definition of "Health Care Provider" found at 45 CFR160.103 are not required to submit an NPI.
- Any provider whose license has been revoked or has been precluded, excluded, suspended and disqualified from participating in any Medicare, or any other government health-related program, or who has opted out of Medicare will be automatically terminated from the Plan.

Below are additional credentialing requirements for physicians applying:

- Signed attestation statement (within 180 days)
- Copy of Florida license(s)
- Education and training, if applicable
- Work history for the past five years (explain the gap of 6 + months)
- Copy of specialty board certification, if applicable
- Hospital admitting privileges, if applicable

- Current certification of insurance (face sheet with expiration date and coverage amounts)
- Explanations for any malpractice history and disciplinary actions
- Copy of applicable certification(s), e.g., board certification, if applicable
- Explanations for any health issues
- Copy of Drug Enforcement Administration (DEA) license, if applicable
- Site Survey for all Primary Care Physicians

Additional documentation may vary depending on provider type and services to be rendered. These requirements will be disclosed to you during the contracting process and collected by your Provider Relations Representative, if applicable.

Recredentialing

Recredentialing is performed every three (3) years or as otherwise required by law or applicable regulations and requires the submission of an updated credentialing application and documentation.

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

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

Long-Term Care Services Providers, Ancillary Facility/Supplier Business Credentialing Requirements

Ancillary and facility providers are not required to use CAQH. Said providers should complete and submit a credentialing application. The application will be provided to you by your Provider Relations Representative.

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

- Signed attestation statement (within 180 days)
- Copy of Florida license(s)

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

Credentialing Requirements for Advanced Non-Physician Practitioners

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

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

Updating Application Documentation

Providers have the right to review, correct and resubmit any of the information to support their credentialing application including but not limited to third-party sources. Corrections must be submitted by the date requested and, in all cases, no later than the completion date of the credentialing process. Delays in returning materials may result in the initiation of the contract termination process. Providers have the right to inquire

about the status of their application. Information shared with Practitioners may include information obtained to evaluate their credentialing application, attestation, or curriculum vitae (CV).

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

Confirmation of Credentialing Status

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

Applications may be delayed for any of the following reasons:

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

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

Minority Recruitment and Retention and Prohibition Against Discriminatory Practices

Florida Complete Care (FC2) does not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of provider's license or certification under applicable state law. (42 CFR 438.12(a)(1)). In addition, FC2 does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments. (42 CFR 438.12(a)(2); 42 CFR 438.214(c)).

Florida Complete Care Provider Guidelines and Responsibilities

Provider Guidelines and Responsibilities

This section is an overview of guidelines and responsibilities for which all participating Florida Complete Care Providers (FC2) are accountable. Please refer to your contract or contact a Provider Relations Representative for clarification.

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

- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii)]
- Use physician extenders appropriately. Physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) should provide direct Member care within the scope of practice
- Clearly identify physician extender titles (examples: MD, DO, ARNP, PA) to Members and to other health care professionals
- Honor always any Member request to be seen by a physician rather than a physician extender
- Provide all services in an ethical, legal, culturally competent manner, free of discrimination against Members based on age, race, creed, color, religion, gender identity, national origin, sexual orientation, marital, physical, mental, or socioeconomic status
- Participate in and cooperate with Quality Improvement, Utilization Management, and other similar programs established by FC2, including allowing FC2 to use provider performance data for quality improvement activities.
- Participate in and cooperate with FC2's Member grievance and appeal procedures.
- Comply with all federal and state laws regarding confidentiality of Member records.
- Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services.
- Must maintain an active and valid business email address at all times; and any changes to your email address must be reported to FC2 within three (3) business days
- Must maintain internet access at all times in order to gain direct access to FC2's Provider Portal
- Maintain communication with appropriate agencies, such as local police, poison control, and social service agencies to ensure Members receive quality care.

- Contact FC2 case manager if Member exhibits a significant change, is admitted to a hospital, or hospice program.
- Maintain accurate medical records and adhere to all FC2's policies governing content and confidentiality of medical records.
- Respond promptly to FC2's request(s) for medical records in order to comply with regulatory requirements.
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.
- Communicate timely clinical information between Providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to FC2, the Member or the requesting party at no charge, unless otherwise agreed.
- Meet all timely access standards.
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.
- Not discriminate in any manner between FC2 Members and non-FC2 Members
- Ensure that the hours of operation offered to FC2 Members is no less than those offered to commercial Members or comparable Medicaid fee for service recipients if Provider serves only Medicaid recipients.
- Not deny, limit, or condition the furnishing of treatment to any FC2 Member based on any factor that is related to health status, including, but not limited to, the following:
    - Medical condition, including mental as well as physical illness.
    - Claims experience
    - Receipt of health care
    - Medical history
    - Genetic information
    - Evidence of insurability
    - Including conditions arising out of acts of domestic violence, human trafficking, or disability
- Freely communicate with and advise Members regarding the diagnosis of the Member's condition and advocate on Member's behalf for Member's health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self- administered regardless of whether any treatments are Covered Services
- Abide by and cooperate with the policies, rules, procedures, programs, activities, and guidelines contained in your Agreement (which includes the most current handbook)

- Accept payment, plus the Member's applicable deductible, coinsurance and/or copayment, as payment-in-full for covered services
- Not balance bill the Member for any differences between the charge and the contractual allowance. The Member is only responsible for any applicable deductible, coinsurance, and/or copayment and non-covered service amounts or services exceeding any benefit limitations.
- Adhere to FC2 business ethics, integrity and compliance principles and standards of conduct as outlined in the Plan's code of conduct.
- Promptly notify us of claims processing payment errors
- Make such records and other information available to us or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA-AS and HITECH requirements.
- Immediately notify us of adverse actions against license or accreditation status
- Maintain liability insurance in the amount required by the terms of your Agreement.
- Notify FC2 of the intent to terminate your Agreement as a participating provider within the timeframe specified in your Agreement.

Provider Guidelines and Responsibilities for Primary Care and Specialists

Florida Complete Care recognizes Family Medicine, General Practice, Geriatric Medicine and Internal Medicine physicians as PCPs.

Florida Complete Care may recognize specialist physicians as PCPs for customers who may require a specialized physician to manage their specific health care needs.

Role of the PCP:

- Ensure that each customer receives treatment as frequently as is necessary based on the customer's condition.
- Develop an individual treatment plan for each customer.
- Submit accurate and timely claims and encounter information for clinical care coordination.
- Comply with FC2's pre-authorization and referral procedures, as applicable.
- Refer members to appropriate FC2 Participating Providers.
- Comply with FC2's Quality Management and Utilization Management programs.
- Use appropriate designated ancillary services.
- Comply with emergency care procedures.
- Comply with FC2's access and availability standards as outlined in this manual, including after-hours care.

- Bill FC2 on the current CMS 1500 claim form or electronically in accordance with FC2's billing procedures
- Ensure that, when billing for services provided, coding is specific enough to accurately capture the acuity and complexity of a customer's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Comply with Preventive Screening and Clinical Guidelines
- Adhere to FC2's medical record standards as outlined in this manual.

The Role of the Specialist Physician

Florida Complete Care (FC2) Members are entitled to see a Specialist Physician for certain services required for treatment of a given health condition. The Specialist Physician is responsible for managing all the health care needs of a FC2 member as follows:

- Provide specialty health care services to customers as needed.
- Collaborate with the member's FC2 Primary Care Physician to enhance continuity of health care and appropriate treatment.
- Provide consultative and follow-up reports to the referring physician in a timely manner.
- Comply with access and availability standards as outlined in this manual including after-hours care.
- Comply with FC2's pre-authorization and referral process, as applicable.
- Comply with FC2's Quality Management and Utilization Management programs.
- Bill FC2 on the CMS 1500 claim form in accordance with FC2's billing procedures
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a customer's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Refer members to appropriate FC2 Participating Providers.
- Submit encounter information to FC2 accurately and timely.
- Adhere to FC2's medical record standards as outlined in this manual.

<u>Access to Care Standards & Availability Requirements</u>

Network Providers are responsible for complying with the following appointment availability standards for regular and routine care appointments, urgent care appointments and after-hours care.

PCPs must provide reasonable access for Members enrolled with Florida Complete Care, including, but not limited to the following:

- Standard visits: (i.e., comprehensive exam, preventive care appointment) within four (4) weeks of request. Routine appointments: within 10 business days or two (2) weeks of request, whichever is sooner; non-urgent, symptomatic appointments within four calendar days of request.
- Urgent appointments: within 24 hours of request; and response by physicians to an emergency call within 30 minutes of receipt of the call during office hours.
- All PCPs shall also assure that Members have reasonable access to a physician by providing:
    - Evening or early morning office hours three or more times per week
    - Weekend office hours two (2) or more times per month
    - Notification to the Member when the anticipated office wait time for a scheduled appointment may exceed 30 minutes.
    - A 24-hour answering service and ensure that each PCP provides a 24-hour answering arrangement, including a 24 hour on-call arrangement for all members

Specialists shall ensure that all Members have reasonable access to a physician by providing:

- Standard (regular/routine) appointments within 30 days.
- Urgent appointments within 72 hours and respond to emergency calls within 30 minutes of an emergency call or leave a message with "call 911 or go to ER.".

Mental Health/Substance Abuse providers ensure Members have reasonable access to a physician by providing:

- Standard/Routine appointments within 10 days
- Urgent / Expedited appointments within 48 hours
- Emergency appointments within six (6) hours or less (Emergency that doesn't represent risk to patient's life)
- Life-threatening emergency care available 24 hours/7 days per week

After Hours Accessibility and Continuity of Care

Florida Complete Care must ensure that medically necessary services are available and accessible to Members twenty-four (24) hours per day, seven (7) days per week, and three hundred sixty-five (365) days per year. This may be through the help of a support center or by referring to facilities that offer services after hours. This includes requiring that all primary care physicians (PCPs) have appropriate back-up for absences.

Provider (primary or specialty care) must provide the plan with at least a 30-day notice when voluntarily terminating from the network and comply with continuance of care policies of the Plan.

Back-up provisions - On-Call and covering providers

In the event that a provider uses the services of other physicians for coverage purposes, covering arrangements shall be made with other physicians except in unusual and unanticipated circumstances such as emergent and urgent care. In all cases, the provider shall arrange with the covering physician that they will accept payment from the health plan according to the Health Plan's Medicare Fee Schedule as payment in full, except for any applicable member cost-sharing amounts. The provider shall ensure that the covering physician will not, under any circumstances, bill members for the covered services, except for any applicable member cost-sharing, and except as otherwise provided in the applicable Member Agreement.

Maintaining Updated Provider Information

Florida Complete Care (FC2) shall maintain a provider directory with accurate provider information. It is important to maintain accurate and up-to-date provider demographics, office and billing information. Providers can notify FC2 of any changes to their provider data records quickly and easily through their Provider Relations Representative.

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

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

- Name / DBA Name / Legal Business Name
- Name changes, mergers or consolidations
- Practicing Specialty
- NPI
- Addresses (Payment, Service, Mailing)
- Contact Info
- Office Hours (including after hours and weekends)
- Staff Lists (Edit/ Add/Remove Providers)
- Practitioner Language(s)
- Staff Language Spoken
- Key Office Staff Updates

- Federal tax id number
- Add/Edit Credentials – Medicare, DEA, Medicaid number.
- Medical Services by Location
- License(s) and Certification
- Hospital Privileges
- Hospital Affiliations
- PCP Panel Updates
- Website URL
- Business e-mail address
- Communication Preferences
- PCMH Qualification
- Notification of no longer accepting new patients
- Gender of Patients serviced
- Age Restriction of patients serviced

Please review your information at www.fc2healthplan.com at least quarterly. If you find information that needs to be updated, please contact your Provider Relations Representative immediately.

Provider Responsibilities When Agreement Is Terminated for Any Reason

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

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

FC2 Is Not Involved in the Corporate Practice of Medicine

Florida Complete Care (FC2) are Provider Service Networks; we do not in any way practice medicine, manage care or direct the care and treatment of an FC2 Member. FC2's function is to facilitate the coordination of Member's care and treatment by a network provider who is managing that Member's care and treatment.

A Member's Selection of Providers

FC2 shall assist the Member in selecting providers by supplying the Member with a list of applicable providers for him or her to choose from. Selection of a provider is within the purview and responsibility of the Member or his or her treating provider using FC2 participating provider directory.

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

Member [Patient] Abandonment

This is an issue that FC2 takes seriously because it directly impacts on the Member. The care, welfare, and safety of the FC2 Member is of paramount concern. FC2 has zero tolerance in this regard.

Patient Abandonment refers to withdrawal from the treatment of a patient without giving reasonable notice or providing a competent replacement. There are no state or federal laws that forbid a physician or any provider from firing a patient, for whatever reason. However, the provider cannot abandon a patient on the spot. The provider must first give the Member notice via written correspondence using certified United States Postal Service (USPS) mail or other trackable private carriers. The served notice must state that the provider-patient relationship has been terminated, either with or without cause. A provider can sever a provider-patient relationship due to no longer participating in the Florida Medicaid or limiting Medicaid patients. The letter to the Member must allow for sixty (60) days from receipt of the notification to seek another provider of his or her choosing from the list of participating providers within the FC2 network. A provider can also select a new provider for the Member, as long as the new provider formally accepts the new patient in either verbal or written form.

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

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

Providers that took care of Member in an emergency setting and the provider allowed for follow-up care must continue to see that Member. Should the provider not want to

continue to see the Member, for any reason whatsoever, the provider can transition the Member out of his or her care as stated by finding a provider of the same specialty that is willing to accept the Member and to whom all clinical records are forwarded. Anything less shall constitute abandonment of the Member.

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

- The Member refuses to cooperate with the provider and its staff.
- The provider is not a participating provider with Florida Complete Care.
- The Member will not pay his or her bills.
- Reimbursement for services has been denied by FC2 or the provider has ceased to be a Florida Complete Care provider.
- You can terminate the provider-patient relationship in the following ways.
- The physician and the patient mutually agree to terminate the relationship.
- The patient unilaterally dismisses (fires) the provider; the Member is unruly and obnoxious to the point where it is in the best interests of all concerned for the provider to quit providing services.
- The provider terminates the relationship after giving the patient written notice and a reasonable amount of time to find another provider.

Marketing Guidelines

The Centers for Medicare and Medicaid Services (CMS) has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential Member toward a specific plan or limiting to a number of plans offered either by the plan sponsor or another sponsor based on the financial interest of the provider or agent. Providers should remain neutral parties to the extent they assist beneficiaries with enrollment decisions.

Florida Complete Care providers may not:

- Offer anything of monetary value to induce Members to select them as their provider.
- Distribute marketing materials/applications in an exam room.
- Urge or steer towards any specific plan or a limited set of plans based on the provider's own interest.
- Collect/accept enrollment applications or scope of appointment forms on behalf of the plan.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Conduct Health Screenings as a marketing activity.

- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are disenrolling from the health plan to encourage re-enrollment in a health plan.
- Make Phone calls or direct, urge or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.
- Advertise using Florida Complete Care's name without FC2's prior consent and potentially CMS approval depending upon the content of the advertisement.

Florida Complete Care providers may:

- Mail or provide a letter to patients notifying them of their affiliation with FC2.
- Provide objective information to patients on specific plan attributes and formularies based on a patient's medications and healthcare needs in the course of treating the patient.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered).
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPs), FC2 marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Provide beneficiaries with communication materials furnished by FC2.
- Refer patients to the plan marketing materials available in common areas.
- Display and distribute in common areas FC2 marketing materials; the office must display or offer to display materials for all participating Medicare Advantage plans if requested by the plan.
- Provide information and assistance in applying for the Low-Income Subsidy
- Display promotional items with the FC2 logo.
- Allow FC2 to have a room/space in provider offices completely separate from where patients receive healthcare services, to provide Medicare beneficiaries with access to a FC2 sales representative.

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

<u>Member Rights and Responsibilities</u>

As a recipient of Medicare and Member of Florida Complete Care our members have the following rights:

- Be treated with courtesy, dignity, and respect at all times.
- Be protected from discrimination; every company or agency that works with Medicare must obey the law; a member cannot be treated differently because of race, color, national origin, disability, age, religion, or sex.
- Have one's personal and health information kept private.
- Get information in a way one understands from Medicare, health care providers, and other vendors.
- Learn about treatment choices in clear language that one understands and participate in treatment decisions.
- Access Medicare information and health care services in a language one understands.
- Get Medicare information in an accessible format, like braille or large print.
- Get answers to your Medicare questions.
- Have access to doctors, specialists, and hospitals for medically necessary services.
- Get Medicare-covered services in an emergency.
- Get a decision about health care payment, coverage of items and services, or drug coverage; when a provider files a claim, notify the member letting them know what will and won't be covered.
- If a member disagrees with the decision of a claim, they have the right to file an appeal.
- Request a review (appeal) of certain decisions about health care payment, coverage of items and services, or drug coverage.
- Be able to file complaints, including complaints about the quality of care.

Fraud, Waste, and Abuse

Florida Complete Care (FC2) maintains a comprehensive Fraud, Waste, and Abuse program. The program offers a special investigative process in accordance with federal and state statutes and regulations. FC2 is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers, and associates doing business with us. FC2 regards health care fraud, waste, and abuse as unacceptable and unlawful activities that are harmful to the provision of quality health care in an efficient and affordable manner. FC2 has implemented a program to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care costs and to promote quality health care. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified in 42 U.S.C. § 1395w-104 and 42 C.F.R. § 423.504(b)(4)(vi)(H).

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment. The term "knowing" is defined to mean that a person with respect to information:

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

Florida False Claims Act

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

Deficit Reduction Act

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

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

Whistleblower Protection

The Federal False Claims Act, the Florida False Claims Act, and the Medicaid False Claims Act have language commonly referred to as "whistleblower" provisions. These

provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently.

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

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

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. FC2 will take steps to monitor contracted providers to ensure compliance with the law.

Definitions of Fraud, Waste, and Abuse

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

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

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

Examples of Fraud, Waste, and Abuse by a Provider:

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

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

Member Abuse, Neglect and Exploitation

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

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

The Warning Signs

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

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

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

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

"Member Exploitation" of a vulnerable adult refers to when a person who:

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

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

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

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

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

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

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

Florida Complete Care (FC2) provides full training on abuse, neglect, and exploitation. Providers must complete abuse, neglect, and exploitation training, including training to identify victims of human trafficking. Please contact your Provider Relations Representative for additional information.

Florida Complete Care Medical Management

As a Provider Service Network, Florida Complete Care (FC2) recognizes the administrative burden providers have when obtaining authorizations for care from various health plans. To better support our members' health care needs, we are committed to decreasing the prior authorization requests for high-quality providers. These include providers who demonstrate a strong understanding and application of medical necessity criteria along with achieving improved health and quality outcomes.

FC2's Prior Authorization Program

Providers should refer to this table for a listing of services typically requiring referral or authorization. As this table is updated on a yearly basis, the presence or absence of a service or procedure on the list does not determine coverage or benefit. Referrals to "out of network" physicians or facilities require prior authorization from the Plan's Utilization Management team.

Service	Requirement	Notes
Hospitalization: Inpatient Emergent Medical and Psychiatric	Notification	Facility must provide notification to the FC2 within one business day of an emergent admission and include clinical notes for review.
Hospitalization: Inpatient Elective (Medical and Psychiatric)	Prior Authorization	
Hospitalization: Inpatient Partial Day	Prior Authorization	
Emergency Room Observation	No Notification is Required	Following the CMS Two-midnight rule notification of inpatient admission is required
Ambulatory Surgery Center	Prior Authorization	
Cardiac and Pulmonary Rehab Services	Prior Authorization	
Certain Prescription Drugs	Prior Authorization	Only those drugs cited on the FC2 formulary
Chiropractic Services	Prior Authorization	

Comprehensive Dental	Prior Authorization	Requests should go to Dentaquest, the FC2 Dental Network.
Diabetic Supplies/Services	No Authorization Required	
Dialysis	Prior Authorization	

Service	**Requirement**	**Notes**
Durable Medical Equipment	Prior Authorization	Must utilize FC2 DME Formulary and Fee Schedule
Hearing Aids	Prior Authorization	
Home Health Services	Prior Authorization	Must have skilled need for the service as defined by Medicare
Hospice	No Authorization Required	Part A transition
Laboratory Services	No Authorization Required	
Medicare Part B Drugs	Prior Authorization	For chemotherapy: Only initial administration requires authorization
Mental Health Specialty Services	Prior Authorization	
Other Healthcare Professionals (SW/NP/PA)	Prior Authorization	*For services outside of nursing facility only
All Out of Network Services	Prior Approval Required	
Outpatient Diagnostic Procedures and Tests	Prior Authorization	Performed outside of a physician office or nursing facility
Outpatient Diagnostic/ Therapeutic Radiology	Prior Authorization	MRI, MRA, CT, CTA, PET, nuclear medicine all require authorization in all places of services; X-rays do not require authorization

Outpatient Hospital Services	No Authorization Required	Must be an FC2 participating facility; non-participating must request prior authorization
Orthotics and Prosthetics	Prior Authorization	Only CMS covered items will be approved; HCPCS codes not covered under

Service	**Requirement**	**Notes**
		Medicare will not be covered nor go for medical necessity review
Part A Skilled Nursing Facility: Post-Acute	Prior Authorization	*Per PBP policy
Part B Therapy - Occupational, Physical or Speech Therapy Services	Prior Authorization	*Per PBP policy
Substance Abuse Services	Prior Authorization	
Transport/Non-Emergent Ambulance	Prior Authorization	

Florida Complete Care (FC2) has also designated certain CPT and HCPCS, as Essential Prior Authorization Code (EPAC). These codes have designated prior authorization status under the following topic headings:

1. Medical/Surgical/Ancillary
2. Pharmaceuticals/Biologicals/Infusion Therapy/ (collectively referred to as “drugs”)
3. Enteral Supplements
4. Behavioral Health / Substance Use Disorder

The rationale for that designation is represented as:

- Defined by community providers
- Procedures, treatments, drugs or equipment that are inappropriate, have dangerous side effects or are experimental or investigational in nature
- Procedures, treatments, drugs or equipment that are the extreme forms of treatment in both cost and risk that require a reasonable level of discourse as to the rationale for that particular choice by the requesting or prescribing provider
- Procedures, treatments, drugs or equipment that are off-label and should be used only for certain health conditions

- Procedures, treatments, drugs, or equipment that are often misused or abused
- Procedures, treatments, drugs, or equipment that a provider requests or prescribes when less expensive procedures, treatments or drugs will work just the same.

FC2 Medicare Benefits and Services

As of the date of publication of this handbook, the following is a list of core benefits and services (Covered Services) that are provided to Florida Complete Care Members.

Medical/Surgical/Ancillary

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

Pharmaceuticals/Biologicals/Infusion Therapy/Enteral

- Drugs requested on an "off-labeled" basis
- Drugs not listed on the FC2 Formulary
- Drugs listed on the Formulary with a prior authorization
- All specialty drugs that do not appear on the Formulary
- Duplication of therapy
- Prescriptions that exceed the Federal Drug Administration (FDA) daily or monthly quantity limits
- Non-formulary brand-name drugs when an equivalent generic exists on the formulary
- Drugs that have a step edit and the first line of therapy is inappropriate or already tried and failed
- Drugs that have an age limit
- Multi-ingredient compounds
- All biological and biosimilar agents
- Infusion and enteral therapy request from a non-participating vendor
- All special needs infusion therapy or enteral feedings that need to be customized for the member
- Prior Authorization for Opioids- In alignment with Florida's Opioid State Targeted Response Project, FC2 will implement formulary changes affecting opioid prescriptions.

Mental Health / Substance Use Disorder

Florida Complete Care (FC2) manages mental and behavioral health services for Members with DSM-5 diagnoses. FC2 care managers will work collaboratively with providers to meet our members' mental health and substance use disorder needs. Members should call 1-833-FC2-PLAN for assistance. Services include:

- Acute inpatient hospitalization
- Partial hospitalization
- Intensive outpatient services
- Electroconvulsive therapy (ECT)
- Psychological testing

Obtaining a Prior Authorization (PA)

A PA is obtained directly online on FC2's Provider Portal, by calling the Utilization Management Unit directly (1-833-322-7526, select the Provider option then press 2), email or by faxing in the request (305-675-6138). In the event that the online service is

off-line, or the provider's online service is off-line, FC2 offers telephone and FAX submissions.

FC2's prior authorization process is rooted in evidence-based physical medicine and surgical practices, current pharmaceutical therapies, and evidence-based mental and behavioral health practices. All providers submitting a prior authorization must submit the clinical information and must cite the source of the medical necessity by means of a clinical guideline, criteria set, or medical policy as set up by the Centers for Medicare and Medicaid. Providers will not be given criteria to follow as part of the prior authorization process.

Utilization Management

The FC2 Utilization Management (UM) Program is made up of the utilization management services FC2 provide Members and providers. This utilization management program applies to the oversight of the medical management process of access of care through the diagnostic and treatment processes, transition of care, and continuity of care that a FC2 member is party. The FC2 UM program is integrated internally and externally to deliver the maximum effectiveness for Members, providers, and external stakeholders.

Utilization Management Philosophy

FC2's utilization management philosophy is Member-centric and collaborative with Members and providers to address Member's physical, behavioral, environmental, and social needs. We strive to achieve seamless integration with our external subcontractors and any external stakeholders for a unified experience for Members and providers.

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

Program Goals

The goals of the FC2 UM program are as follows:

- Develop and maintain a consistent UM Program using established criteria and guidelines to make medical necessity determinations
- Follow Medicare Coverage Guidelines
- Improve transitions of care across health care settings, providers, and services

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

Contacting us for Authorization

Providers submit requests for service authorizations for review by the FC2 Utilization Management (UM) Department via fax or phone and may inquire on authorization status on the Provider Portal as follows:

- Fax: 1-305-675-6138
- Phone: 1-833-FC2-PLAN, Option 2
- Provider Portal for authorization status: www.fc2healthplan.com

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

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

Clinical Documentation

If the provider, via fax or web portal, submits clinical information such as labs, images, or clinical notes, the authorization representative attaches the information to the case in the FC2 medical management system for review by the licensed staff.

If an FC2 provider submits a service authorization request telephonically, a licensed staff may review the request immediately for determination upon request. Licensed

staff are available to non-clinical authorization representatives during authorization intake for any questions. Non-clinical staff inform providers of any request that does not require authorization however, they do not issue denials of any kind. When conducting a review of a FC2 service authorization request, FC2 accepts information from any reasonably reliable source that will assist in the authorization process. Any FC2 treating provider may submit information for the authorization request. Authorization staff collects only the information necessary to authorize the admission, procedure or treatment, length of stay, or frequency or duration of services.

All UM determinations are made solely on the medical information obtained at the time of the review determination. For a retrospective request, determinations are based on the medical information available at the time the care was provided. UM determinations are made based solely on the appropriateness of care, service, and existence of coverage. FC2 does not specifically reward practitioners or other individuals for issuing denials of coverage nor do any financial incentives for UM decision makers encourage decisions that result in underutilization.

Out of Network Providers and Prior Authorizations

In the case where a member must utilize an out of network provider, FC2 requires out-of-network providers to obtain prior authorization. However, members of FC2 Health Plan (PPO I-SNP) may want to voluntarily obtain a coverage determination to ensure that the service will be covered.

Please Note: *The Member will be financially liable for the cost of unauthorized services from non-participating providers and vendors. Thereby, please do not encourage Members to pursue out-of-network services or products to have the utilization reviewed retrospectively. FC2 does not do retro-reviews of out-of-network/non-participating services or products on an elective basis. The only retro-review allowed will be in an emergency.*

FC2 Concurrent Review

Concurrent Review is the process of evaluating admissions and continued stay requests when Member is hospitalized in an acute, skilled nursing or acute rehabilitation facility, or other inpatient admission. Here, primary review staff review all emergent admissions for medical necessity, reasonableness or appropriateness and continued stay requests for medical necessity and appropriate utilization of inpatient resources. During the concurrent review process, licensed staff also identify occurrences of over/ underutilization, physician practice patterns, ways to improve Member outcomes and monitor cost effectiveness. The concurrent review process is used for the following functions:

- To assess the medical necessity of admissions and continued stays, the appropriateness of the admission, the cost-effectiveness of the setting, level of care, and services.
- To estimate the probable and goal length of stay of the admission.
- To monitor the services to determine if they are provided timely and efficiently.
- To screen for potential quality of care, utilization, and risk issues.
- To begin discharge planning early in the inpatient stay to satisfy transition of care needs.
- To work with hospital staff to recommend alternate care options as appropriate.
- To identify and refer Members to case management or disease management services.
- To identify clinical issues in the Member and refer to the medical director for discussion with the Member's primary care physician or treating physician.
- To identify quality of care concerns and refer to the medical director for discussion with the attending staff, hospitalist, and/or risk management staff.
- To communicate with facility staff and other providers to coordinate the Member's care.

Emergency Room Observation (Two-midnight Rule)

Emergency cases that only require observations, but do not require inpatient admissions are addressed in accordance with the participating hospitals' observation policy. FC2 follows the CMS "Two-Midnight Rule," as both a clinical and business practice. These cases do not require authorization for the observation/stabilization period (up to 24 hours). Admission to the hospital and/or continued stay beyond the anticipated 48-hours will require prior authorization just like any other emergency admission.

Second Opinions

FC2 allows Members to obtain a second medical opinion in any instance in which the Member requests or disputes his or her physician's opinion of the reasonableness or necessity of a covered service or is subject to a serious injury or illness that requires an opinion of a specialist. FC2 shall, in accordance with 42 CFR 438.206(b)(3) and s. 641.51, F.S. Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the Member.

FC2 may deny reimbursement rights granted under this section in the event the Member seeks in excess of three (3) such referrals for the same complaint, illness, surgical intervention or treatment per year if such subsequent referral costs are deemed by FC2 to be evidence that the Member has unreasonably overutilized the second.

opinion privilege. Member denied reimbursement under this section has recourse to grievance procedures as specified in ss. 641.495 and 641.511, F.S.

The second opinion, if requested, is provided by a physician chosen by the Member who is a participating physician listed in the FC2 provider or a nonparticipating physician located in the same geographical service area of the organization should there be no same specialist in the geographic service area. Prior approval is required and must be made either by the Member or the nonparticipating provider. No payment shall be made to the nonparticipating provider without prior authorization. Liability for payment may be that of the Member depending on the FC2 contract held by the Member.

The Member is free to seek~~s to~~ consultation with his or her PCP for assistance on choosing a second opinion physician, as long as the selection by the PCP is within the FC2 participating network. Any choice by either the Member or the PCP to utilize an out-of-network provider is permissible, but only with a prior authorization from FC2; and FC2 shall only provide payment coverage to the provider in the amount of all charges being consistent with usual, reasonable, and customary fees in the regional community. FC2 may require that any tests requested by a non-participating provider be conducted by a participating in-network provider or vendor.

Medical Claims Review

All medical claims review requests are reviewed in the same manner as any prior authorization request for medical necessity. When considering a medical claims review authorization request, the primary reviewer reviews information that was submitted or made available at the time the service was initiated or rendered, or product initiated. The case is referred to the medical director for review if medical necessity is not established. The medical director reviews all available clinical information and can obtain a peer-to-peer discussion or seek to obtain more information or clarification in the case in order to make a determination regarding the medical necessity of the case.

Once the medical director makes a determination, the case is processed in the same manner as cited above for both approvals and adverse determinations.

Notice of Certification

This is the Medicare approved notice whether a case has been approved or denied. When a case is approved, the case is issued a Notice of Certification (NOC) as valid proof for the Member and requesting provider. This certification can be via written in the form of an e-mail or fax or verbally by phone, depending on the type of request.

This notification includes CPT/HCPCS codes authorized, effective dates for the authorization and an authorization number for tracking purposes. For non-participating providers, FC2 provides the notice of certification for services within one (1) business day of the approval. For concurrent review requests, the notification also includes the number of days or units authorized on the review, the next review date, total number of days or units authorized, and the date of admission or start date of services.

Reversal of an Approval

FC2 does not reverse an approval unless there is a suspicion of fraud, waste, or abuse that has come to the Plan following the approval.

Discharge Planning and Transition of Care

Discharge planning is a proactive process that begins at the time of admission. The discharge plan is the first step in the transition of care process. The Discharge Plan is the responsibility of the hospital or the transferring agent as the clinical blueprint for the transition of care of that member to the next level of appropriate care. This is the first step in the transition process.

Transition planning is the responsibility of the Plan. It provides that the transition from one setting to the next is medically necessary, reasonable, or appropriate; that the transition site is participating in the Plan as a network provider, and that the transition site is appropriate to service the member's needs.

FC2's CVS Pharmacy Network

FC2's network of participating pharmacies includes all of the CVS pharmacies nationwide along with many other regional and local pharmacies, such as Publix, Walmart, and CVS. Please check the FC2 website for details or contact CVS at 1-844-740-0625 for details and questions.

FC2's Over-the-Counter Expanded Benefit

FC2 has expanded its pharmacy benefit by including over the counter (OTC) drugs, supplies, and personal items. A catalog of available items can be found on the FC2 website at www.fc2healthplan.com to access the OTCHS catalog or by calling 1-888- 628-2770; TTY: 1-877-672-2688 or go directly to the order online at https://www.cvs.com/otchs/flcompletecare.

Medicare Excluded Drugs

Medicare explicitly has excluded certain drugs from Medicare Part D coverage. These drugs are listed in the Appendix of the CVS/FC2 Drug Formulary. These drugs will not be covered for any reason whatsoever as they are excluded as a direct result under Part D law; they are EXLUDED. Any request for prior authorization for an excluded drug will be dismissed administratively with a notice of non-coverage to the member.

Difference Between Part B and Part D Drugs

Part B is the member's medical coverage under the Medicare Advantage Part C program. This part pays for things like doctor visits, lab tests, and home health care, which all come under the FC2 as the Medicare Advantage Part C plan. The Part B drug component also covers certain medications that must be administered by a licensed medical professional that cannot be self-administered by the member. A listing of these drugs comes under the CMS HCPCS system of "J" codes and the AMA CPT codes for vaccines. Part B code drugs come under a separate FC2 Part B Drug Formulary. Part B only those drugs found are this formulary are covered. These drugs all require prior authorization. Also, in the Part B category is vaccines and is specialized durable medical equipment like diabetic test strips, nebulizers, CPAP, all types of wheelchairs, and customized products.

Part D drugs is the prescription drug coverage component. Part D pays for any prescribed drugs regularly to manage chronic conditions. It also pays for any medications that a member takes for a short period of time, such as antibiotics. Part D are all prescribed drugs that can self-administered by the member. When a Medicare Advantage Part C Plan administers this benefit, it is referred to as an MA-PD drug plan.

Vaccine Coverage

Medicare Part B covers most vaccines patients need. Medicare Part D plans cover all commercially available vaccines, except those Medicare Part B covers, when they are reasonable and necessary to prevent illness.

FC2: Expanded Benefits and Services

FC2 offers the following expanded benefits:

- Over the counter (OTC) Medication/Supplies
- Emergency Preparedness Meals
- Post- Discharge Meals
- Medically Tailored Meals
- Fresh Produce Box
- Legal Aid
- Comprehensive Dental Benefits
- Podiatry Services
- Dental Services
- Healthy Grocery Benefit

FC2's expanded benefits may be changed on a Contract year basis in a manner and format approved by CMS.

FC2: Telemedicine Coverage Provisions

FC2 will offer its members access to services through telemedicine that comprises any provider licensed to render a diagnosis and render treatment for that diagnosis such as, a physician, nurse practitioner, physicians' assistant through face-to-face encounter via an electronic or digital portal such as, a computer, telephone, or cell phone. Telemedicine providers are required to adhere to all applicable rules and regulations. FC2 telemedicine providers must be in compliance with the Health Insurance Portability and Accountability Act (HIPPA) as well as state and federal laws governing patient privacy. All telecommunication equipment and telemedicine services must meet the technical safeguards required by 45 CFR 164.312.

Any provider approved by FC2 to provide telemedicine services through their FC2 provider agreement must have protocols to prevent fraud and abuse that address:

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

UM Timeliness

- FC2: Pre-service Standard Requests
  Staff process pre-service routine requests within seven (7) calendar days from the date of receipt. Staff provide electronic or written notification of the decision to providers and Members also within seven (7) calendar days from the date of receipt. All pre-service requests are treated as routine unless the provider requests otherwise.

- FC2 Pre-service Expedited Requests
  Staff process pre-service urgent requests within 48 hours from the date and time of receipt. Staff provide electronic or written notification of the decision to providers and Members also within 48 hours from the date and time of receipt. Providers can indicate a request as STAT for it to be processed urgently.

- FC2 Concurrent Review
  Staff process concurrent requests (requests for admission or continued stay) within 24 hours from the date and time of receipt. If the request for continued stay is received less than 24 hours before the current authorization expires, staff process the request within 48 hours. UM staff provide electronic and written notification of the decision to providers and Members within 24 hours from the date and time of receipt.

Organization Determinations

Organization Determinations

An organization determination (approval or denial) occurs for administrative or clinical reasons.

An organization determination is any determination (i.e., an approval or denial) made by Florida Complete Care (FC2), or its delegated entity with respect to the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services,

- Payment for any other health services furnished by a provider (other than FC2), that the enrollee believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by FC2,

- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the enrollee believes should be furnished or arranged by FC2,

- Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment, or

- Failure of FC2 to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

In circumstances where there is a question whether or not FC2 will cover an item or service, the enrollee, enrollee's representative, or the provider on behalf of the enrollee, has the right to request a pre-service organization determination (prior authorization) from the plan. Such pre-service requests to the plan (even to an agent or contractor of the plan, such as a network provider) are requests for an organization determination and must comply with the applicable regulatory requirements. Whenever an enrollee contacts FC2 to request a service, the request itself indicates that the enrollee believes FC2 should provide or pay for the service. However, when a provider declines to furnish a service requested by an enrollee, this is not an organization determination because the provider is making a treatment decision (which may be based on the provider's judgment about whether the item or service should be part of the enrollee's treatment plan or whether the provider is willing to furnish the item or service, regardless of coverage by the plan).

If the enrollee wishes to request information about coverage of the benefit, the enrollee must contact FC2 to make a coverage request for the service in question, or the provider may make the coverage request on the enrollee's behalf. FC2 must educate enrollees and providers that when there is a disagreement with a provider's decision to decline to furnish a service or a course of treatment, in whole or in part, the enrollee has a right to request and receive an organization determination from FC2 about whether coverage of the benefit would be provided; such determination about coverage would likely address if the item or service is medically necessary. Further, enrollees have the right to seek treatment from other providers (such as from another provider in the network).

When FC2 UM staff do not have sufficient information to conduct a review or render a medical necessity determination, staff may request additional information from the enrollee and request a 14-day extension. FC2 UM staff must request the clinical information no less than three (3) times prior to issuing the denial. For a pre-service standard request, the requests for clinical information must be made within seven (7) calendar days. For a pre-service expedited request, the requests for clinical information must be made within 48 hours.

<u>Notice of Denial of Medical Coverage</u>

FC2 issues written notices of denial of medical coverage to the Member and requesting provider/facility. The notice includes the following items:

- The principal reason for the determination to deny coverage
- The clinical rationale used to make the determination
- Instructions on how to request a copy of the UM criteria used
- Instructions on how to initiate an appeal including the following information
- An explanation of the appeal process including Members' right to representation
- Appeal timeframes
- Description of appeal rights including the right to submit written comments, documents, or other relevant information to the appeal
- Description of the expedited appeal process for urgent denials

FC2 gives the Member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. FC2 provides the Member with a written notice of the denial of medical coverage for any service authorization decisions, using the template provided by the Centers for Medicare and Medicaid Services (CMS) and Chapter 13 Managed Care Manual Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. FC2 includes an identifying number on each notice of denial of medical coverage in a manner prescribed by CMS.

FC2 UM staff mail the notice of denial of medical coverage as follows:

- For non-expedited pre-service decisions-within 14 calendar days of the request.
- For expedited pre-service decisions–*within 72 hours of the request.
- For denial of payment, at the time of any notice of denial of medical coverage affecting the payments of services.
- For service authorization decisions not reached within required timeframes constitute a denial.

Member Appeal (Reconsideration) Process

FC2 permits a Member, Member's authorized representative, or a provider acting on behalf of Member (with a signed and dated and specific instruction citing the Member's request for the provider to advocate for him / her) to appeal coverage decisions. The denial notice provides instructions on how to file an appeal including the toll-free number to reach FC2 to request an appeal. Member, the Member's authorized representative, or a provider acting on behalf of Member may also request an expedited appeal when a delay in the decision may seriously jeopardize the Member's health or life.

- A standard appeal is processed within 30 days from the date a written request for appeal is received.
- An expedited appeal is processed within 72 hours from the date a written request for appeal is received.

Expedited grievance applies in cases in which the appeal was either downgraded from expedited to standard status OR if the appeal was extended (an additional 14 calendar days) in the member's best interest. If the request for an expedited appeal is denied, the Appeal staff will notify the Member and/or requestor that the appeal will be processed in standard timeframes.

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

The process is similar to that of the initial PA process, but it does not involve the same reviewers. The reviewer is new to the case reviewing it for the first time & timeframes for Review are listed below:

I-SNP and IE-SNP: E*xpedited requests can be accepted over the phone in certain circumstances.*

- Pre-service and Part B expedited: 72 hours for review
- Part B standard: 7 calendar days for review
- Pre-service standard: 30 calendar days for review
- Post service: 60 calendar days or review

FIDE SNP: *Standard & Expedited appeals can be accepted over the phone & writing*

- Pre-service, Part B and post-service expedited: 72 hours for review
- Part B standard: 7 calendar days for review
- Pre-service and post-service standard: 30 calendar days for review

The Grievance & Appeal specialist assigned to the case will review the appeal information received. The review includes:

1) Request additional information such as medical records if needed,
2) review all applicable guidelines such as LCDs, NCDs, Evidence of Coverage, etc. build the case file
3) Present the appeal in the Grievance & Appeal workgroup meeting (Leadership from different departments and the Medical Director).
4) Once the group reaches a determination on the appeal, the appeal is processed To submit a written notification to the requestor of the determination made in the case.

The Grievance & Appeals specialist communicates with the UM department to update the denial in the system and place it in an approved status. Then the Grievance & Appeals specialist will proceed to notify the member or requesting provider verbally of the overturn.

I-SNP and IE-SNP Letters contains these elements:

The result of the appeal: upheld or overturned the original determination.

- Information about additional appeal rights
- Notice that the provider/member has the right to submit additional information that may be important to the review.
- Information that the provider/member have the right to get a copy of the case file being sent to Maximus for upheld cases.
- For overturned appeals, letters will include the following:
    - For authorization, it will include authorization number, the service or item being overturned and provider name.
    - For payment, it will include the dates of service, claim number, amount paid, date paid and check number.

D-SNP FIDE Letters contains these elements:

- The result of the appeal: upheld or overturned the original determination
- The clinical rationale used when making the appeal decision if the denial is upheld.
- Reference to the benefit provision, guidelines, protocols, or other similar criteria on which the appeal decision was based.
- Information about additional appeal rights including Medicaid Fair Hearing for Medicaid covered benefits.
- For Medicaid-covered benefits, information that the member can have the benefits continued which the appeal is pending if applicable.
- For overturned appeals, letters will include the following:
    - For authorization, it will include authorization number, the service or item being overturned and provider name.
    - For payment, it will include the dates of service, claim number, amount

paid, date paid and check number.

Appeal staff maintains records of all appeals in the FC2 Grievance & Appeals module in the ECare system. The appeal records contain the following information:

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

Emergency Services

Providers are not required to obtain prior authorization for any emergency services to screen and stabilize Member. FC2 defines emergency services using the "prudent layperson" definition in compliance with the Balanced Budget Act of 1997. FC2 follows the Medicare definition of, "emergency services" defined in the Medicare Managed Care Manual Chapter 4 Section 20.2.

Accordingly, an emergency medical condition is "a medical condition manifesting itself by acute symptoms of enough severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction to any bodily organ or part." FC2 will not deny payment for emergency services if an FC2 representative instructs the Member to seek emergency services.

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

Confidentiality and Use of PHI

FC2 considers protected health information (PHI) private and confidential and has policies and procedures in place to protect PHI against unlawful use and disclosure. FC2 protects the privacy of PHI in accordance with federal and state privacy laws including HIPAA privacy laws. When necessary or appropriate for the care and treatment of Members, company operations, or to conduct related activities, FC2 uses and/or discloses the minimum necessary PHI. FC2 does not require an authorization from the Member to use or disclose PHI in the following health care operation activities:

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

Clinical Practice Guideline Monitoring and Improvement

Clinical practice guidelines (CPGs) are used to assist practitioners and Members in their decisions about appropriate care for specific clinical circumstances. Florida Complete Care uses national, state, or specialty recognized guidelines. These CPGs have been adopted with input and recommendations for local physicians and practitioners through our quality committee processes.

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

- The American Diabetes Association – Medical Care in Diabetes
- US Preventive Services Task Force – Colorectal, Breast, Cervical, Smoking Cessation, etc.
- National Heart, Lung & Blood Institute – Asthma Management
- The American College of Cardiology – Heart Failure, Coronary Artery Disease, Hypertension
- The American Psychiatric Association – Treatment of Depression
- American Lung Association - Chronic Obstructive Pulmonary Disease
- National Institute of Health & Care Excellence – Bipolar Disorder

FC2 selects several key indicators from at least two (2) of these clinical practice guidelines to monitor the process and outcomes of care related to these practice guidelines. This may require a periodic review of the participating physician office's clinical records.

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

Disease Management

FC2 offers condition-specific interventions and programs focusing on the improvement of specific clinical conditions and promote continuous quality improvement for our members. Providers are encouraged to collaborate with us to close gaps in clinical care. This can be done by referring Members with chronic conditions into our Disease Management Programs, where they will receive condition-specific coaching and education related to their condition.

FC2 offers programs for the following conditions:

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

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

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

FC2 care managers work with the Member in collaboration with any third-party health plans the Member may also be a member of, providers and support systems, to perfect our disease management intervention by leveraging all resources available to the Member.

FC2 gives interventions which range from educational information for both the provider and Members to disease management training from our care managers to better empower Members. Members will receive different levels of interventions found by the disease risk level or need.

Core components of the FC2 Care management/Care Coordination process include collaboration between PCP, behavioral health provider (when applicable) and specialty providers and is essential to support and provide both the appropriate level of care and continuity of care. Our care managers act as a health navigator and liaison for the Member working in collaboration with the PCPs and specialty providers to ensure that there is open communication, education, preventative care and proper care and treatment for the Member. Each covered disease has its own individualized program specific to the characteristics and treatment plan(s) for that disease. More information on these programs can be found on our website at www.fc2healthplan.com.

FC2 conducts interdisciplinary care team meetings which involve multiple disciplines from our care team, the Member, their caregiver or family support, other service providers or community organizations, more care managers involved, the PCP and specialty provider(s). We discuss the Member's care during the interdisciplinary care team meeting along with identifying personal goals and interventions to achieve Member-centric outcomes.

FC2 believes that a well-integrated disease management program will improve health outcomes. We evaluate our performance measures yearly.

Claims Processing and Payment Guidelines

This section explains certain aspects of the claim process. For a more in-depth outline, please refer to our website at www.fc2healthplan.com.

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

Type of Claims Submissions

Paper Claims

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

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

Paper claims should be mailed to:

Florida Complete Care
Attn: Claims
PO Box 21688
Eagan, MN 55121

Electronic Claims

Electronic Claim Submissions allow providers to safely submit and track HIPAA-compliant electronic claims to us via *Availity* without manual intervention. **Florida Complete Care's Payer ID is FLCPC.**

Electronic claims may be filed through *Availity* or send your claims through a billing service or clearinghouse to transmit to *Availity* and then route to us. *Availity* edits transactions according to the HIPAA-AS requirements. A number of payer-specific edits

are also performed before routing transactions to FC2. To register with *Availity*, go to https://www.availity.com/provider-portal-registration .

Additionally, *Ability* is also available for providers to transmit claims to Florida Complete Care (FC2). *Ability* can provide easy to use forms configured for non-traditional services which Florida Complete Care provides throughout its network of providers. *Ability* will connect all transactions with standard payer services with FC2 to transmit invoices and transactions with FC2. To sign up with Ability, contact Ability Network Enrollment Department at 888.499.5465 or email enrollmentsupport@abilitynetwork.com.

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

Visit the Provider Portal through our FC2 website at www.fc2healthplan.com for additional electronic transmission support information.

Prompt Claims Processing/Timely Filing Limits

Providers must file claims within the time set forth in their Florida Complete Care participating provider Agreement(s) unless applicable law requires a greater time period for filing of claims. If applicable to a particular benefit agreement, current Florida law and other legal requirements provide that claims must be filed within 365 days after the date of service for non-participating providers and receipt by the provider of the name and address of a patient's health insurer. For participating providers, claims must be filed withing 180 days of the date of service.

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

Claims and Encounter Data Submissions

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

Inclusion of a complete and accurate list of diagnosis codes associated with the Member at the time of the encounter, including any chronic conditions not necessarily treated at the time of the encounter, will help ensure correct coding of the encounter. Additionally, it helps us match patients with appropriate care and disease management programs, and ensure Members are properly classified by risk programs. We

encourage you to purchase current copies of CPT, HCPCS, and ICD-10-CM codebooks.

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

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

- Verify coverage. Members can have changes in their health insurance benefit plans or eligibility. You should always verify coverage through our Provider Portal which can be accessed via our website at www.fc2healthplan.com. Submit the entire Member identification (ID) number. Submit the Member ID number, not the Member's Social Security number. The 835 electronic remittance advice will indicate when Member's ID number is processed with a different identifier than was submitted.
- Complete all claim entry fields. To receive proper reimbursement, the claim information must be completed in its entirety. Incomplete or inaccurate information will result in a claim denial.
- Enter the date of onset, if applicable. All ICD diagnosis codes in the 800-900 range require a date of onset (injury, accident, first symptom, etc.).
- Use valid codes. CPT, HCPCS, and ICD codes are updated quarterly. Make sure you or your billing service is using the most up-to-date codes.
- Report an unlisted code only if unable to find a procedure code that closely relates to or accurately describes the service performed. Unlisted codes require documentation and therefore cannot be submitted electronically.
- Use diagnosis codes that indicate a general medical exam when billing for "preventive" health screening exams. Claims for these services will be denied if other diagnosis codes are used.
- Submit modifiers affecting reimbursement in the first and second position on claims. A procedure code modifier, when applicable, provides important additional information about the service performed. When multiple modifiers are necessary for a single claim line, modifiers should be submitted in the order that they affect payment.
- Submit multiple procedures on one claim. All procedures performed on the same date of service, by the same provider for the same patient should be submitted on one claim.
- Submit all applicable diagnosis codes. Code to the highest level of specificity possible. Most 3- digit codes require a fourth or fifth digit.
- Include the National Provider Identifier (NPI) for rendering physician and billing physician or group. Both the CMS-1500 and UB-04 include fields for the NPI.

CMS-1500:

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

The above blocks are split to allow your FC2 provider number in the shaded area and your NPI in the non-shaded area labeled NPI.

UB-04:

- Field 56 is for the NPI of the Billing Facility/Provider
- Field 76 is for Type 1 NPIs (Attending Provider)
- Field 78 and 79 are for Type 1 NPIs (other referring provider)
- Use the correct Tax ID or Social Security number. For participating providers, the Tax ID Number (TIN) reported on the claim should match the TIN found within the provider agreement, which is the provider/legal entity's payee TIN. Should your legal entity TIN change, please contact your FC2 Network Manager directly before claims are submitted containing the new information
- When services are rendered in a facility that is NOT associated with the billing entity, enter name and address along with NPI if available
- Valid 9-digit zip codes are required
- Submit the correct billing provider information
- Individual Physicians/Providers: Enter the name, address, phone number, and NPI of the individual physician, if services were rendered in a solo practice
- Groups: Enter the name, address, phone number and NPI of the group practice
- Valid 9-digit zip codes are required

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

Duplicate Claims

Avoid sending duplicate claims. For claims status, use our Provider Portal which can be accessed via our website at www.fc2healthplan.com, or contact 1-833-FC2-PLAN, option 3. If filing electronically, be sure to also check your clearinghouse file acknowledgment and EBR for claim level **failures**. Allow 15 days for electronic claims and 30 days for paper claims before resubmitting.

Corrected claims

Please follow the instructions under "Corrected Claims" below to ensure accurate information is provided and processed correctly.

Taxonomy Code

Claims should contain the proper provider taxonomy code.

NPI and Sub-Part Identifiers

Claims should also contain the proper National Provider Identifier (NPI) for sub-units of a hospital, if applicable, or if the sub-unit is a participating with Florida Complete Care.
If a NPI was not obtained for sub-units of the hospital, ensure the proper taxonomy code is used when billing the Plan.

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

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

Medical Records Review for Claims Payment

Under certain circumstances, Florida Complete Care (FC2) will suspend claims for medical review in order to determine if the services rendered are covered. Clinical information/medical records for these select procedures/services may be requested to support claims adjudication. Failure to submit the clinical information/medical records may result in processing and payment delays.

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

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

Requesting Medical Records (Claims Payment Use)

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

- The routing sheet must be only used for the matching documentation. Do not copy the routing sheet for multiple claims; it is for a specific claim and Member.
- The routing sheet must always be the top sheet attached to the documentation regardless of the mode of return (i.e., fax, mail).
- When the documentation is returned by fax, the routing sheet must be fed from the top of the page to the bottom of the page.
- Do not attach separate sets together. Fax one information package at a time. Our electronic receiving system only recognizes the first page as the routing sheet and catalogs all subsequent pages accordingly.
- Do not write on the routing sheet except to place an "X" within the applicable boxes to designate what type of documentation is attached to the routing sheet.
- Do not send double-sided copies.
- Do not return the original letter that was sent with the routing sheet.

Mail the documentation to:

Florida Complete Care
Attn: Claims – Medical Records
PO Box 21688
Eagan MN 55121

Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed. When submitting a corrected claim, providers should use the UB with type xx7; or a HCFA with frequency 7.

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

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

Claim Status/Inquiry

Providers may submit claim status inquiries for a variety of reasons (e.g., corrected claims, late charges, medical records, etc.). When submitting a claim inquiry, complete the Provider Reconsideration/Administrative Appeal Form and attach it to your claim. A wide range of self- service options are available through the Provider Portal at www.fc2healthplan.com to enable providers to view a summary of claims that have previously been paid, rejected, or pended. Please refer to the Frequently Referenced Self Service Section for additional information on the self-service tools.

Rejected Claims

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

Pharmacy Claim (Medical Claim)

Submit claims for payment directly to FC2 following the guidelines below.

J Code Drug Unit Billing

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

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

Diagnosis Required for J Code Billing

Include the primary diagnosis code on the claim, which is the reason for the drug use. Claims submitted with only a V58.1 diagnosis code (Other and Unspecified After-Care Maintenance Chemotherapy) will require additional information prior to a coverage decision.

Modifiers are Required for J Code Billing

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

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

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

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

Claim Payments and Statements

Remittance Advice

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

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

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

Overpayment Policy

Overpayment Recovery

An overpayment is a reimbursement in excess of the monetary obligation that we have with respect to a particular claim. Florida Complete Care pursues timely recovery of all

identified overpayments using various methods. For claims subject to Florida law, refer to Florida Statutes Sections 627.6131 and 641.3155.

Offsetting Policy

FC2 uses a payment offsetting policy to recover claim overpayments. FC2 recovers the overpaid amount by offsetting (deducting) from current or future claim payment(s). In other words, the overpaid amount is subtracted from the payment for claims on a subsequent remittance.

Before offsetting, if applicable, FC2 follows state law, which requires advance notification of the intent to recover overpayments through an offsetting process. According to their Agreement, participating providers are required to promptly notify the Plan of claims processing or payment errors and allow for the use of offsetting/ recouping overpayments.

Plan Identified Overpayments

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

When determined that a claim was paid incorrectly, FC2 may make claim adjustments without requesting additional information from participating health care providers. In the case of an overpayment, FC2 will request a refund at least 30 calendar days prior to implementing a claim adjustment, or as provided by applicable law. A provider will see the adjustment on the EOB or RA. When additional or correct information is needed, we will ask you to provide it.

FC2 provides advance notification of the intent to recover overpayments by sending a refund request letter. Information contained in the letter includes:

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

Actions to complete upon receipt of the refund request letter

1. Review the letter for the appropriate request reason and claim data.
2. Contact the Provider Contact Center if additional basic information is needed to process the refund.
3. Submit a refund within 40 days.
4. At a minimum, clearly notate the following information associated with the refund payment:
    - Member ID number
    - Claim number
    - Date of service
    - Patient name
    - Patient account number
    - Invoice number (preferred)

5. Notify FC2 in writing, within 35 days of letter receipt, if the overpayment request is being contested or denied. Clearly, notate the contested or denied portion of the claim overpayment request and provide specific reasoning.

Provider Identified Overpayments

If a provider identifies a claim for which they were overpaid, they must send the overpayment within 30 calendar days from the date of identification of the overpayment. If overpaid funds are not returned in a timely manner, FC2 may request repayment. If repayment is not received within 45 days of a written request, FC2 may take action to recover the overpayment, to the extent permitted by applicable law, including but not limited to, by offsetting against future claim payments.

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

Option 1: Contact the Provider Contact Center

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

Option 2: Refund the overpayment

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

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

Overpayment applies to all claims

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

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

  Florida Complete Care
  PO Box 21688
  Eagan, MN 55121

Provider Complaints, Appeals, and Dispute Resolution

Florida Complete Care (FC2) maintains effective and proven procedures for handling provider inquiries, complaints, and disputes, including receipt and tracking methods of escalation processes and resolution timeframe requirement as well as follow-up responsibilities.

Our Provider Call Center team offers an increased level of service for our network providers. Providers can call a toll-free number to interact with a Provider Services Representative, who can immediately assist with inquiries related to claims payment and other issues. Florida Complete Care's goal is first call resolution for all provider inquiries.

Provider Complaints

Non-Claims Related Complaints

Providers submitting complaints concerning non-claim issues shall have 45 days to file their written complaint. These include any complaint, including clinical issues, with the exception of filing a clinical appeal as the provider or on behalf of the Member. FC2 will notify providers within three (3) days of filing a complaint that complaint has been received and will provide to the provider an expected date of resolution. FC2 will

contact the provider verbally or in writing after receiving the complaint. Written complaints can be filed by USPS letter, email, or fax. FC2 will resolve all non-claims provider complaints within 90 days of its documented receipt; and will provide written notice of the disposition to the provider within three (3) business days of the resolution date and will include the basis of the resolution.

Claims Related Complaints

For provider complaints concerning claims issues, providers shall have 60 days from the date of final determination of the primary payer to file a complaint. FC2 will notify providers within three (3) days of filing a complaint that complaint has been received and will provide to the provider an expected date of resolution. FC2 will contact the provider verbally or in writing. FC2 will resolve all claims-related provider complaints within 60 days of receiving the complaint and will provide written notice of the disposition and the basis of the resolution within three (3) business days of resolution.

Providers can contact FC2 using any of the methods below:

- In person through your Provider Relations Representative
- Via phone call to the Provider Call Center: 1-833-FC2-PLAN, Option 2
- Email through our provider self-service website: www.fc2healthplan.com
- In writing via U.S. mail to:

Florida Complete Care
Attn: Provider Complaints
PO Box 21688
Eagan, MN 55121

Provider Claims Disputes

Providers may request reconsideration of how a claim is processed, paid, or denied. These requests are referred to as disputes. FC2 has a defined Provider Dispute Resolution process for use by providers who are dissatisfied with how a claim is processed, paid, or denied.

If a provider would like FC2 to reconsider a claim adjudication decision, providers may submit reconsiderations for a variety of reasons (e.g., claim allowance, coordination of benefits, provider contract issue, etc.). When submitting a claim Reconsideration, provide a written statement of the dispute, along with the following information:

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

Send Dispute to:

Florida Complete Care
Attn: Provider Disputes
PO Box 21688
Eagan MN 55121

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

Medical Records Guidelines

FC2: Member Medical Record Requirements

All providers rendering service to Florida Complete Care Members must follow the Member Medical Record standards set forth in state and Federal regulations and the provider contract.

1. Documentation Requirements

   a) All providers must:

      1. Ensure medical records establish the medical necessity for and document the extent of services provided.
      2. Sign and date each medical record within two (2) business days from the date and time of service, or otherwise authenticate the record by signature, written initials, or computer entry. Electronic signatures are permissible as defined in Chapter 668, Part I, F.S.
      3. Initial rubber-stamped signatures.
      4. Include appropriate patient identifiers including at least name, date of birth, and gender.
      5. Ensure content and format of records are uniform, consistent, and clinical entries are easily accessible.
      6. Have evidence in the record of the Member signed HIPAA document.

b) Unless otherwise specified providers must document the following information for *each* service visit or encounter with Member:

1. Chief complaint or purpose of the visit
2. Date(s) of service
3. Description of services rendered (as applicable)
4. Diagnoses
5. Diagnostic tests and results (as applicable)
6. History and physical assessment (as applicable)
7. Prescribed or provided medications and supplies (as applicable)
8. Updated information about allergies and sensitivities
9. Progress reports
10. Referrals to other services (as applicable)
11. Scheduling frequency for follow-up or other services (as applicable)
12. Treatment plan (as applicable)

c) For Members seen two (2) or more times, the clinical record should contain the following:

1. Documentation of use of tobacco and other substances.
2. A complete immunization history or notation that immunizations are up to date.
3. Medication reconciliation after a hospital discharge.
4. An initial (and annually thereafter) history and family history profile must be completed and documented.
5. A comprehensive physical examination must be completed and documented annually.
6. Unresolved problems from previous office visits shall be noted and addressed in subsequent visits.
7. There is evidence of patient education/counseling regarding self-care, specific illness, or preventive medical care las well as health education and wellness promotion referrals or activities.
8. There is evidence of a discussion regarding treatment preferences, or an "Advance Directive" noted in the patient's record.
9. Evidence in the record B/P at least for each visit.

2. Electronic Records

a) Providers that create or maintain electronic records must develop and implement an electronic records policy to comply with the applicable state and federal laws, rules, and regulations to ensure the validity and security of electronic records. Electronic record policies must address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.

b) Providers that maintain electronic records must have the ability to produce electronic records in a paper format within a reasonable time, upon Florida Complete Care's request.

3. Recordkeeping Requirements. Providers must retain all business records, medical-related records, and medical records, as defined in Rule 59G-1.010, F.A.C., according to the requirements specified below, as applicable:

   a) Providers may maintain records on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law. All records must be accessible, legible, and comprehensible.
   b) Regardless of format, the system used must protect and ensure security and integrity of the records.
   c) Providers must retain all records related to services rendered to Florida Complete Care Members for a period of at least ten (10) years from the date of service per CMS requirements for providers participating in a Medicare Managed Care program or network.

4. Right to Review Records

   a) Authorized state and federal agencies, and their authorized representatives, may audit or examine provider records. This requirement applies to the provider's records and records for which the provider is the custodian. Providers must give authorized state and federal agencies, and their authorized representatives, access to all Florida Complete Care (FC2) Member records.
   b) All records must be provided regardless of the media format on which the original records are retained by the provider at the time of the request. All medical records may be reproduced electronically or onto paper copies as authorized by the requestor.

FC2: Confidentiality of Member Information

Confidentiality and accuracy of Member's record must be maintained at all times. Florida Complete Care (FC2) requires that all providers comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for privacy and protection of Member data. The privacy of any information that identifies a particular Member must be safeguarded. Information from or copies of Member's record may only be released to authorized individuals.

Providers must take steps to prevent unauthorized individuals from gaining access to or altering Member's record. Original records may only be released in accordance with state laws, court orders or subpoenas, and timely access by Members to the information that pertains to them must be ensured. Additionally, FC2 and providers must abide by all federal and state laws regarding confidentiality and disclosure of all Member records and information.

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

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

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

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

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

In all cases, psychotherapy notes are private and may not be disclosed without the Member's consent, including disclosure to a health care provider other than the originator even in cases where the disclosure is for treatment purposes. Exceptions for disclosures required for law enforcement, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible.

Cultural Competency

Cultural Competency is the ability to interact effectively with people of different cultures. In practice, both individuals and organizations can be culturally competent. Culture can include race, ethnicity, age, gender, sexual orientation, disabilities, religion, income level, education, geographical location, or profession. FC2 strives to ensure the delivery of culturally competent services and provision of linguistic access to all Members of Florida Complete Care's plan, including those with limited English proficiency. FC2 utilizes guidance from Culturally and Linguistical Appropriate Services (CLAS) Standards as developed by the Department of Health and Human Services, Office of Minority Health (OMH). The CLAS Standards provide a blueprint for health care organizations to implement culturally and linguistically appropriate services that will advance health equity, improve quality, and help eliminate health care disparities.

FC2 will provide effective language access services, including interpreters and printed materials in multiple languages that reflect the cultural/ethnic/racial composition of our member population. Language assistance options are available at no cost to the Member. Oral interpretive services are available either in-office or telephonically. Providers are able to obtain interpreter services for telephonic contact and in- office visits by calling 1-833-FC2-PLAN, Option 2. Information on how to obtain these services is documented in this provider handbook and through other means such as the provider newsletter and the FC2 provider website.

- Language Line services are available 24 hours a day, seven (7) days a week in 140 languages to assist providers and Members in communicating with each other during urgent/emergent situations, non-urgent/emergent appointments as requested, or when there are no other translators available for the language requested.

- TDD/TTY access for Members who are hearing impaired is available through 711.

Quality Improvement

Quality Programs

Physician and provider contracts require cooperation with quality activities and participation in our Quality Improvement Program. As part of our Quality Improvement Programs, we may utilize information such as claims, encounter data and/or medical record information to improve the health care of our Members.

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

- Clinical Practice Guideline adoption and adherence monitoring
- Condition-Specific Interventions and Programs
- Credentialing/Re-credentialing
- Adverse Incident Reporting and Analysis
- Member and Provider Satisfaction Surveys
- Preventive Health Monitoring and Improvement
- Quality Performance Indicators
- Under-Utilization and Over-Utilization Assessment
- Monitoring of provider accessibility and availability
- Monitoring of member satisfaction
- Member grievance resolution, trending, and interventions
- Monitoring of member safety
- Monitoring of continuity and coordination of care
- Monitoring, clinical measurement and improvement of the SNP Model of Care
- Measurement and improvement of member health outcomes
- Chronic Care Improvement Program (CCIP)
- Collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS)
- Collection and reporting of Structure and Process measures
- Provider peer review activities
- Collection and reporting of Part C Reporting Elements
- Collection and reporting of Part D Medication Management data

Quality Performance Indicators

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

- Measures serve as indicators to both consumers and the public in evaluating how well the Florida Complete Care health care delivery systems are meeting customer needs in these areas.
- Measures can also be used by health care providers to evaluate and improve care and service to Members.
- The performance measures were developed through a review of work conducted by leaders in the field of health care quality improvement.
- Florida Complete Care will continually monitor and adjust the quality performance indicators utilized in its Quality Improvement Program. A listing of the quality performance indicators and measures used in the Quality Improvement Program can be found on the Florida Complete Care website. Links to Clinical Practice Guidelines that have been adopted are also available on the website.

Audit Programs

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

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

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

Notification/Confirmation Responsibilities:

Prior to a provider audit, Florida Complete Care will send the provider written notice of the upcoming audit ten (10) working days prior to the audit start date. Audit notifications can be sent to the provider by email, mail, or fax.

The notification will at a minimum indicate the following:

- Type of audit
- When applicable, a list of claims to be reviewed containing claim number, Member name, patient account number, and date of service

- A request for medical documents or components to support billing
- The plan may request a formal entrance conference with applicable provider designee and our audit staff when conducting an Onsite Audit; the formal entrance conference will be held on day one of the onsite visit

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

Provider Audit Responsibilities:

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

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

During the audit, the provider agrees to:

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

Audit Findings:

- The provider designee will review/communicate the preliminary audit findings with provider personnel authorized to finalize audit findings.
- Provide formal acceptance of each finding in anticipation of the exit process.
- When applicable, refund Member copayments and correct the audited accounts to ensure no further adjustment activity occurs.

Florida Complete Care Audit Responsibilities:

- Perform audit
- Discuss preliminary findings with the provider; discussion and revision of the audit findings may be conducted by telephone, fax, mail, or additional onsite meetings

- Mail a copy of the preliminary audit findings to provider designee; discussion and revision of the audit findings may be conducted by telephone, fax, mail, or additional onsite meetings

Plan Responsibilities in Exit Process:
An exit conference will be conducted with the provider designee, including an overview of audit findings. Exit conferences may be conducted via telephone if an in-person conference is not required.

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

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

Vendor Audits

We may use contracted vendors to supplement audit activities when considered necessary to reduce risk and exposure to the company. Contracted vendors must follow all audit procedures when conducting audits for us. Vendor activities are centrally coordinated by Florida Complete Care (FC2) to ensure statewide consistency. In these audits, the provider will need to send the check to the address contained in the audit letter, not directly to Florida Complete Care. The directions indicated in the audit letter need to be followed to ensure appropriate adjustments and credits are made to the audited claim.

Provider Non-Compliance/Penalties

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

- The provider will be notified in writing, and we will place the provider on corrective action for 30 days. During this time, we will work with the provider to achieve compliance.
- Provider compliance will be reassessed after 30 days. If it is determined that a provider is complying with encounter/claim data submission requirements, the provider will be removed from corrective action. However, if the provider is still non-compliant after 30 days, we may initiate termination of the Agreement.

Additional Medicare Advantage Requirements

As a Medicare Advantage (MA) organization, FC2 and its network care providers agree to meet all laws and regulations applicable to recipients of federal funds. If you participate in the network for our MA products, you must comply with the following additional requirements for services you provide to our MA members.

- You may not discriminate against members in any way based on health status.
- You must allow members direct access to screening mammography and influenza vaccination services.
- You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services.
- You must provide female members with direct access to a women's health specialist for routine and preventive health care services.
- You must make sure members have adequate access to covered health services.
- You must make sure your hours of operation are convenient to members.
- You must make sure medically necessary services are available to members 24 hours a day, seven (7) days a week.
- Primary care providers must have backups for absences.
- You must adhere to CMS marketing regulations and guidelines. This includes, but is not limited to, the requirements to remain neutral and objective when assisting with enrollment decisions, which should always result in a plan selection in the Medicare beneficiary's best interest. CMS marketing guidance also requires that providers must not make phone calls or direct, urge, or attempt to persuade Medicare beneficiaries to enroll or disenroll in a specific plan based on the care provider's financial or any other interest. You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
- You must provide services to members in a culturally competent manner taking into account limited English proficiency or reading skills, hearing or vision impairment, and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to tell members of health care needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member's medical record whether they have executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.

- You must make sure any payment and incentive arrangements with subcontractors are specified in a written Agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act, and the Anti-Kickback Statute; and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164.
- The payments you receive from us or on behalf of us are, in whole or in part, from federal funds and you are therefore subject to certain laws applicable to individuals and entities receiving federal funds.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the MA program and disclose all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- You must comply with our processes for notifying members of your Agreement terminations.
- You must submit all Risk Adjustment Data, and other MA program-related information we may request, within the time frames specified and in a form that meets MA program requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing, that the data is accurate, complete, and truthful, based on your best knowledge, information, and belief.
- You must comply with our MA medical policies, Policy Guidelines, Coverage Summaries, quality improvement programs, and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance, and other indicators as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes, but is not limited to, providing requested medical records within two (2) hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.