Florida Health Care Plans®

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FHCP PROVIDER RESOURCE GUIDE

Revised January 2022

INTRODUCTION

Welcome to the Florida Health Care Plans (FHCP) Provider Resource Guide, formally known as the FHCP Provider Handbook. The Resource Guide is for physicians, hospitals, ancillary providers and facilities. While this Resource Guide is designed primarily for providers participating in any FHCP network, it contains useful information for providers considering joining FHCP or who are providing services to FHCP. We realize the administrative requirements of managing a member's health care can be complex; this Manual was developed to assist in understanding requirements and serve as a resource for answering questions you may have about our networks, products, programs, coding and claims filing guidelines, policies and procedures.

The Resource Guide is not intended to be a complete statement of polices or procedures for providers. Other policies and procedures, not included in this manual, may be posted on our website, Provider Portal, or published in special publications, including but not limited to, letters, bulletins, or newsletters. Links to applicable policies and procedures are included as applicable throughout this manual.

Any section of this Resource Guide may be updated at any time. FHCP may notify providers of updates in a variety of ways, depending upon the nature of the update, including mailings, publication in our provider newsletter, posting to the FHCP Provider Portal (www.fhcp.com – link is in top left corner) or posting to other locations on our website at www.fhcp.com. Unless noted otherwise in this document, information specific to Medicare members can be found at www.FHCPMedicare.com.

In the event of any inconsistency between information contained in this Resource Guide and the agreement(s) between you or your facility and FHCP, the terms of such agreement(s) shall govern (referred to herein as your "Agreement"). Also, please note that at various times when dealing with FHCP, you may be provided with available information concerning an individual's status, eligibility for benefits, and/or level of benefits in relation to your participation status with FHCP. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Payment shall only be made in accordance with the applicable benefit plan in the individual's actual eligibility as determined by such benefit plan. Further, the presentation of FHCP identification cards in no way creates, nor serves to verify an individual's status or eligibility to receive benefits.

Participating Providers are encouraged to conduct business with us electronically through the FHCP Provider Portal which can be accessed via FHCP's website, whenever possible. Non-participatingProviders may use Availity (www.availity.com) to obtain FHCP eligibility or benefit information.

Please note that we may change the location of a website, a benefit plan name, branding or the member identification card identifier. When these changes occur and apply to you, we will communicate such changes to you.

We will provide you with notice of any changes and display needed information via updates to this Guide. Updates can be viewed in the "Provider Education" section of our website at https://www.fhcp.com/for-providers/. The current version of applicable FHCP policies and procedures are available upon request by contacting the FHCP Provider Services Department at 386-615-5096 or 1-800-352-9824, Opt. 1 + 5096. Requests can also be made via email to FHCPProviderRelations5@fhcp.com.

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IMPORTANT NEWS AND UPDATES FOR ALL PROVIDERS

Doing business with us is easier and faster than ever when you take advantage of the wealth of information and resources available to you online. All providers can stay up-to-date on our latest products and programs, referral guidelines and process changes by accessing bulletins, newsletters, Referral Guides and other valuable resources and tools on our website at www.fhcp.com. Participating providers can also access the FHCP Provider Portal by clicking on and logging into "Provider Portal" located in the top left-hand corner above the FHCP logo on each page of our website. Non-participating providers can obtain information from Availity at www.Availity.com.

ADDITIONAL RESOURCES FOR PARTICIPATING PROVIDERS VIA THE FHCP PROVIDER PORTAL

Provider Newsletters

While you are on our website, we encourage you to visit the "For Providers" Announcements page to review current and past issues of the "FHCP Provider Newsletter" and other updates. Frequently visiting this page provides supplies you with current information regarding FHCP initiatives and updates to policies.

Health Care Reform

The Affordable Care Act (ACA) provides for the creation of Marketplaces (Exchanges) for individuals to purchase health insurance. FHCP Marketplace plans are based on existing product portfolios and use existing provider network arrangements which apply to all FHCP fully insured commercial members.

As a reminder, per your Agreement(s) with FHCP related to commercial members, you have agreed to see our members who are enrolled in a product that uses a network in which you participate. As such, you are not permitted to exclude members from service because they enrolled in our products through the Marketplace.

FREQUENTLY REFERENCED SECTIONS

For your convenience, some of the more frequently referenced resources and guidelines have been migrated into separate appendices for ease of access and easier print capability. These appendices are part of the Manual and you must comply with such provisions as may be set forth in your participating provider agreement with us. We may make changes to such appendences from time to time, and to the extent required under your Agreement, we will provide you with notice of any such changes.

FHCP Provider Portal User Guide

Referral Guides specific to geographic service areas:

- **Referral Guidelines for Brevard County**
- **Referral Guidelines for Volusia/Flagler Counties**
- **Referral Guidelines for Seminole County**
- **Referral Guidelines for St. Johns/Putnam Counties**

Formulary Information for Medicare Members

Formulary Information for Non-Medicare Members

FHCP Network Access Standards & Measurement Results:

- **Practitioner Access Analysis**
- **Network Access Analysis**
- **Practitioner Availability Analysis**

Provider Survey Annual Results Report

FHCP General Wellness Guidelines

Provider Billing of Dual Eligible Medicare Part C Enrollees (MLN SE1128 Revised)

FHCP Online Provider Directory

FHCP Notice of Privacy Practices

FHCP Policies and Procedures

Additional specific FHCP Policies and Procedures are noted as appropriate throughout this document. These Policies and Procedures are part of the Resource Guide and you must comply with same as set forth in your participating provider agreement with us. We may make changes to such Policies and Procedures from time to time. We will provide you with notice of any changes and display needed information via updates to this Guide. Updates can be viewed in the "Provider Education" section of our website at https://www.fhcp.com/for-providers/. The current version of applicable FHCP policies and procedures are available upon request by contacting the FHCP Provider Services Department at 386-615-5096 or 1-800-352-9824, Opt. 1 + 5096. Requests can also be made via email to FHCPProviderRelations5@fhcp.com.

CONTACT US

The “For Providers” section (https://www.fhcp.com/for-providers/) provides updated contact information for FHCP providers and members. “For Providers” also supplies you with important information regarding

- Medication Formularies
- Announcements of interest to FHCP Providers
- How to work with FHCP’s Provider Relations Department
- Referral, Prior Authorizations and Orders
- Claims
- Resources and Support

FHCP Call Center

The Florida Health Care Plans Call Center is a multi-functional department that is operational 24 hours per day/ 7 days per week aiding and direction to Providers, Staff, Hospitals, Patients and their families. The Call Center also collects data to assist with the coordination and satisfaction of care and works collaboratively with the Utilization Management Division, which consists of the Central Referral Department, Case Management Utilization Review Department, as well as the Member ServicesDivision. The Call Center also provides support to FHCP Administration for collecting information regarding hospital encounters.

During normal business hours, from 8:00AM to 5:00PM, the Call Center can be reached by calling (386) 226-4542. After 5:00PM and until 8:00AM, Monday through Friday and all-day Saturday, Sunday and holidays, the Call Center can be reached by Providers, Hospitals and Members by calling Florida Health Care Plans at 1-800-352-9824.

Department Contacts

In addition to the above and various tools on FHCP’s website, specific telephone contact information is summarized below:

Service/Department	***Local Contact Number***	***Toll-Free Contact Number***
General FHCP Inquiries	386-676-7100	800-352-9824
Provider Services	386-615-5096	800-352-9824, Opt. 1 + 5096
Member Services	386-615-4022	877-615-4022
Enrollment & Eligibility	386-676-7176	800-352-9824, Opt. 1 + 7176
Referrals	386-238-3230	800-352-9824, Opt. 1 + 3230
Cost Estimator Center	386-615-5068	800-352-9824, Opt. 1 + 5068
24-Hour Nurse Advice Line		866-548-0727
Coordination of Care	386-238-3284, ext. 7288	855-205-7293, Opt. 1 + 7288
Transition of Care	386-615-5017	855-205-7293, Opt. 1 + 5017
Diabetes/Health Education	386-676-7133	877-229-4518
Mail Order Pharmacy	386-676-7126	800-232-0216
Pharmacy Service Center	386-676-7173	800-352-9824, Opt. 1 + 7173
Claims	386-615-5010	800-352-9824, Opt. 1 + 5010
Utilization Review	386-676-7187	866-676-7187
Compliance	386-676-7100	800-352-9824
Risk Management	386-676-7100, ext. 5042	800-352-9824, Opt. 1 + 5042

FHCP's standard business hours are 8:00AM to 5:00PM, Monday through Friday. However, as noted above, assistance is available through our after-hours Call Center from 5:00PM to 8:00AM, Monday through Friday, on weekends, and holidays.

You can also contact Provider Services by email at FHCPProviderRelations5@fhcp.com.

FHCP also has access to over 200 languages through a translation line and can help with your interactions with FHCP members, coverage documents and other information in the language of your patient's choice. If you require this assistance, please contact our Provider Relations Department to make this request.

CONTINGENCY PLAN FOR EMERGENCIES AND NATURAL DISASTERS

During a national/statewide emergency or natural disaster make every reasonable attempt to follow normal business procedures. In the event, you are unable to adhere to those procedures, follow the guidelines below:

- You will be issued a series of bulletins (time permitting) prior to any hurricanes, pandemics or, after a disaster strikes via FHCP mass fax containing information relating to FHCP operations, pharmacy info, network adjustments, facility availability, etc.

- Information about FHCP compliance with State or Federal Directives related to a state of emergency is published on FHCP's website. Such information includes emergency services hours and locations, coverage of non-participating provider claims, and other health and safety information.

- In cases of a declared State of Emergency by State or Federal Officials, FHCP relaxes requirements that HMO members use network providers for services. All claims for covered services during a specified State of Emergency period are covered at the HMO benefit level for all members.

- FHCP Provider Services coordinates alternative site placement for displaced network Providers within FHCP facilities, where possible. Provider Services also helps secure alternative placement sites in health system facilities when needed.

- FHCP's Claims Administrator prioritizes claims payments, identifies alternative worksites for displaced Claims Department workers, etc. where possible.

- If you are unable to verify member eligibility and benefits by phone or electronically through the FHCP Provider Portal:
    - Accept a valid FHCP identification card (ID) and picture ID, or
    - Accept a FHCP application acknowledgement/acceptance letter and picture ID

FHCP PROVIDER NETWORK AVAILABILITY & ACCESS STANDARDS

Consumers value timely access to medical care. Florida Health Care Plans (FHCP) monitors primary care, behavioral health, and high-volume and high-impact specialty care practitioner geographic availability and member access to routine and urgent appointments as well as primary care after-hours access accessibility annually against the following standards, and initiates actions as needed to improve.

High Impact Specialties are oncology (medical and radiation) practitioners who treat conditions that have high mortality and morbidity rates and where such treatment requires significant resources.

High Volume Behavioral Health is defined as those Behavioral Health Practitioners who had the most encounters with Members and whose combined encounters are at least 50% of the total behavioral health service encounters within the 12-month performance review period.

High Volume Specialties are Obstetricians/Gynecologists for Commercial and Marketplace Networks, and Gynecologists for Medicare Networks.

Commercial/Marketplace Network Availability Standards for the number of Practitioners:

Primary Care (PCP) – The Network will contain:

- Pediatricians: at least one (1) pediatric PCP for every 2500 Members ages birth to 18 years old. At least 75% of pediatric PCP panels will be open to new HMO Member assignment within the GeographicService Area
- Internal Medicine: at least one (1) internal medicine PCP for every 2500 Members ages 18 years and older. At least 75% of internal medicine PCP panels will be open to new HMO Member assignment within the Geographic Service Area
- Family/General Practice: For purposes of measurement, Family (FP) and General (GP) Practitioners will be combined. At least one (1) FP/GP PCP for every 2500 Members ages 2 years and older will be available. At least 75% of FP/GP PCP panels will be open to new HMO Member assignment within the Geographic Service Area
- Combined PCP types: at least one (1) PCP for every 2500 Members. At least 75% of all PCP panels will be open to new HMO Member assignment within the Geographic Service Area.

Specialty Care – The Network will contain:

- High Volume Specialty Care – at least 90% of High Volume Commercial/Marketplace Network OB/GYN specialists will be open to accepting new HMO members as patients within the Service Area.
- High Impact Specialty Care - at least 95% of High Volume Commercial/Marketplace oncology specialists will be open to accepting new HMO members as patients within the Service Area.
- High Volume Behavioral Health – At least 90% of High-Volume Behavioral Health Practitioners or Providers participating in FHCP's HMO Network will be open to accepting new HMO Members as patients within the Geographic Service Area.

Commercial/Marketplace PCP Practitioners and certain Providers geographic distribution

Conformance to standards below are monitored annually via GeoAccess analysis of Practitioner or Provider locations in relation to Member residences, when such residence is located within the Service Area.

Primary Care (PCP):

- Pediatricians: 80% of Members age birth to 18 years shall have a pediatric PCP office site located within 20 miles of their place of residence.

- Internal Medicine: 85% of Members 18 years and older shall have an internal medicine PCP office site located within 20 miles of their place of residence.
- Family/General Practice: 85% of Members age 2 and older shall have a FP/GP PCP office site located within 20 miles of their place of residence.
- Combined PCP Types: 85% of all Members shall have a PCP office site located within 15 miles of their place of residence.

Specialty Care:

- High Volume Specialty Care Practitioners: 90% of Members shall have access to such Practitioner office sites within 20 miles of their place of residence,
- High Impact Specialty Care Practitioners: 90% of Members shall have access to such Practitioner office sites within 20 miles of their place of residence,
- High Volume Behavioral Health Practitioners: 90% of Members shall have access to at least one High Volume Behavioral Health Practitioner service type that is located within thirty (30) miles of Member residence,
- Emergency/Urgent Care Providers: Within the Service Area, 90% of Members shall have access to an emergency/urgent care Provider located within thirty (30) miles of Member residence,

Medicare Product Type Practitioners & Providers

FHCP must demonstrate that if offers an adequate contracted Network sufficient to provide access to Medicare covered services, as required by 42 CFR 422.112(a)(1). Standards for the number and geographic distribution of Medicare Network Practitioners are set forth by CMS annually in the CMS Health Service Delivery (HSD) Reference file for each County within FHCP's Medicare Product service area.

Medicare Primary Care (PCP) – The Network will contain:

- Internal Medicine: at least one (1) internal medicine PCP for every 2500 Medicare Members ages 18 years and older. At least 75% of internal medicine PCP panels will be open to new HMO Member assignment within the Geographic Service Area.
- Family/General Practice: For purposes of measurement, Family (FP) and General (GP) Practitioners will be combined. At least one (1) FP/GP PCP for every 2500 Medicare Members ages 2 years and older will be available. At least 75% of FP/GP PCP panels will be open to new HMO Medicare Member assignment within the Geographic Service Area
- Combined PCP types: at least one (1) PCP for every 2500 Members. At least 75% of all PCP panels will be open to new HMO Member assignment within the Geographic Service Area.

Medicare Specialty Care – The Network will contain:

- High Volume Specialty Care – at least 90% of Medicare Network GYN specialists will be open to accepting new HMO members as patients within the Service Area.
- High Impact Specialty Care - at least 95% of High-Volume Medicare oncology specialists will be open to accepting new HMO members as patients within the Service Area.
- High Volume Behavioral Health – At least 90% of High-Volume Behavioral Health Practitioners or Providers participating in FHCP's HMO Network will be open to accepting new HMO Members as patients within the Geographic Service Area.

Medicare Network Provider Geographic Availability.

Primary Care (PCP):
Internal Medicine: 85% of Medicare Members 18 years and older shall have an internal medicine PCP office site located within 20 miles of their place of residence.
Family/General Practice: 85% of Medicare Members age 2 and older shall have a FP/GP PCP office site located within 20 miles of their place of residence.

Combined PCP Types: 90% of all Medicare Members shall have a PCP office site located within 15 miles of their place of residence.

Medicare Network Specialty Care:

- High Volume Specialty Care Practitioners: 90% of Medicare Members shall have access to such Practitioner office sites within 20 miles of their place of residence,
- High Impact Specialty Care Practitioners: 90% of Medicare Members shall have access to such Practitioner office sites within 20 miles of their place of residence,
- High Volume Behavioral Health Practitioners: 90% of Members shall have access to at least one High Volume Behavioral Health Practitioner service type that is located within thirty (30) miles of Member residence,
- All Other Medicare required specialties: FHCP must demonstrate that its Medicare Network does not unduly burden Medicare Members in terms of travel time and distance to Network Practitioners/Providers. These time and distance metrics speak to the access requirements pertinent to the residence locations of FHCP Medicare Product enrollees, relative to the locations of the Network Practitioner/Provider. FHCP shall demonstrate that ninety percent (90%) of Medicare Members (or more) have access to at least one Practitioner/Provider, for each CMS specialty type, within CMS established time and distance requirements for the period being measured. The CMS criteria may vary by "county type" to account for differences in patterns of care (Large Metro, Metro, Micro, Rural, CEAC).

Primary Care Physician Appointment Access

The summaries below describe access monitoring standards and methodology for measuring FHCP compliance in meeting accessibility standards for each line of business. To review FHCP's most current results report regarding Provider Network Availability & Access Monitoring and Improvement Process, please go to the "Frequently Accessed Sections" at the beginning of this document.

Standards and Methodology

FHCP monitors primary care physician (PCP) appointment accessibility and after-hours' access to ensure members have access to primary care 24 hours a day, 7 days a week.

FHCP does so by utilizing responses captured in the annual CAHPS survey for Commercial, Marketplace/ACA and Medicare members. FHCP also records and follows up on member complaints and appeals regarding access to their primary care physician and records requests for and utilization of out-of-network access, using such data to monitor and identifying issues members may experience with access to primary care services. The FHCP Provider Services Department also conducts telephone surveys to ensure after-hour care information is available to members.

The following are the CAHPS questions utilized in this standard:

<u>For Commercial</u>:

"6. In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"

"4. In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?"

<u>For Marketplace/ACA</u>:

"20. In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as soon as you needed?"

"21. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"

The table below lists the PCP standards, measurement method, and measurement frequency for each aspect of performance that is monitored.

PCP Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care routine appointments	At least 80% of members report they always or usually obtained check-up or routine care as soon as they needed (CAHPS question 6)	CAHPS member satisfaction survey	Annually
Primary care urgent appointments	At least 80% of members report they always or usually obtained urgent appointments as soon as they needed (CAHPS question 4)	CAHPS member satisfaction survey	Annually
Utilization of Out of Network PCPs	Utilization rate of HMO members with claims for routine Out of Network PCP services within FHCP service area is less than 15 claims per 1000 members	Claim analysis	Annually
Access complaint analysis for appointments	Rate of member complaints about appointment access is less than 0.5 per 1000 Members	Complaint analysis	Annually
Access appeal analysis appointments	Rate of member appeals about appointment access is less than 0.5 per 1000 Members	Appeal analysis	Annually
Primary care after hours care	100% of PCP offices surveyed have an after-hours access mechanism that meets health plan standards	Calls to PCP offices after hours (details below)	Annually

PCP After-Hours Access Measurement Methodology

A universe of all Participating PCP group practice offices was used to assess whether the offices have an after-hours access mechanism which meets FHCP standards. FHCP surveyed 358 PCP practices in

FHCP's HMO networks for Medicare, Commercial, and Marketplace/QHP Members. Most PCP's participate in all three networks, so where there is overlap that PCP group practice can count for each Network's results.

FHCP staff completed the Group Demographics cells, filling in the group name, telephone number (use the number published in the practitioner directory), practice location address and names of PCPs in the practice. One call covers all PCPs practicing at the practice location. Staff completed the Survey Data Collection Information cells, filling in the date and time of data collection, the name of the staff person conducting the survey, and the survey type. Calls are made AFTER normal business hours, OR on weekends or holidays only and not during the business day.

The FHCP After-Hours Access Survey Protocol is organized into three sections based on the type of after-hours access the office location has: answering service, answering machine, or no response. Also, the answering service and answering machine sections have two sub-categories: urgent requirement, and emergency requirement.

Results from each surveyed practice are calculated to determine the office's score in relation to the following criteria.

a. Answering service response standard for urgent situations: The answering service will either offer to page the doctor on call, so that the doctor can call Member back; or offer to telephonically transfer Member's call directly to the doctor on call.
b. Answering service response standard for emergency situations: The answering service will direct the Member to contact 911 or go to nearest ER if he/she feels it is too emergent to wait for doctor to call them.
c. Recorded response standard for urgent or emergency care: The PCP office telephone recording shall provide instructions on how to page the doctor if a situation is urgent; or instructs the Member to call 911 for emergencies or go to the nearest ER or urgent care center if the situation cannot wait until the next business day.

Behavioral Health Appointment Access

FHCP monitors behavioral health appointment access to determine whether members can receive timely appointments based on severity of illness. FHCP does so by conducting telephone surveys by staff to ensure appointment access to both prescriber and non-prescriber behavioral health Practitioners is available to members; recording and following up on member complaints and appeals regarding access tobehavioral health services; utilizing responses captured in the annual CAHPS ECHO survey for Commercial and Medicare members; and compiling requests for and utilization of out-of-network data to monitor and identify issues members may experience with access to behavioral healthcare services practitioners and providers..

The table below sets forth the access standards, measurement method, and measurement frequency for each aspect of performance that is monitored for both prescribing and non-prescribing Practitioners.

Behavioral Health Standards and Measurement Methods by Appointment and Practitioner Type			
Access Measure	**Standard and Performance Goal**	**Measurement Method**	**Measurement Frequency**
Prescriber behavioral health non-life-threatening emergency appointments	85% will provide access to care for a non-life-threatening emergency within 6 hours	Appointment access survey	Annually

Behavioral Health Standards and Measurement Methods by Appointment and Practitioner Type			
Access Measure	**Standard and Performance Goal**	**Measurement Method**	**Measurement Frequency**
Prescriber behavioral health non-life-threatening emergency appointments	100% will refer members to other available network practitioners or to the ER when unable to provide access to care for a non-life-threatening emergency within 6 hours	Appointment access survey	Annually
Prescriber behavioral health urgent appointments	85% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	Appointment access survey	Annually
Prescriber behavioral health new patient routine appointments	80% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	Appointment access survey	Annually
Prescriber behavioral health established patient routine follow-up appointments	80% of offices report a third available routine appointment is open for an established patient within 14 days.	Appointment access survey	Annually
Non-prescriber behavioral health non-life-threatening emergency appointments	85% will provide access to care for a non-life-threatening emergency within 6 hours	Appointment access survey	Annually
Non-prescriber behavioral health non-life-threatening emergency appointments	100% will refer members to other available network practitioners or to the ER when unable to provide access to care for a non-life-threatening emergency within 6 hours	Appointment access survey	Annually
Non-prescriber behavioral health urgent appointments	85% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	Appointment access survey	Annually

Behavioral Health Standards and Measurement Methods by Appointment and Practitioner Type			
Access Measure	**Standard and Performance Goal**	**Measurement Method**	**Measurement Frequency**
Non-prescriber behavioral health new patient routine appointments	80% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	Appointment access survey	Annually
Non-prescriber behavioral health established patient routine follow-up appointments	80% of offices report a third available routine appointment is open for an established patient within 14 days	Appointment access survey	Annually
Complaints about behavioral health access	Rate of member complaints about behavioral health appointment access is less than 0.5 per 1000 members	Complaint analysis	Annually
Appeals about behavioral health access	Rate of member appeals about behavioral health appointment access is less than 0.5 per 1000 members	Appeals analysis	Annually
HMO member - urgent and routine requests for out-of-network access to behavioral healthcare service practitioners and providers.	Rate of HMO member requests for urgent and routine referrals to out of network behavioral health practitioners and providers is less than 0.5 per 1000 members	Referral Request analysis	Annually
HMO member - utilization of out of network behavioral healthcare service practitioners and providers.	Rate of HMO member claims from out of network behavioral health practitioners and providers is less than 15 per 1000 members	Claims analysis	Annually
ECHO survey results re routine and urgent appt access for Getting Treatment Quickly	Rate of member responses about behavioral health Getting Treatment Quickly ECHO Plan summary rate is at or greater than 70%.	ECHO Member Satisfaction Survey Q3, Q5, and Q8	Annually

SPECIALTY CARE PHYSICIAN APPOINTMENT ACCESS

Standards and Methodology

FHCP monitors OB/GYN, medical oncology and radiation oncology routine and urgent appointment accessibility to ensure members have access to high volume and high impact specialty medical care in a timely fashion.

In addition to monitoring specific high volume and high impact access, FHCP monitors and identifies issues members may experience with access to non-behavioral specialty care, practitioners and providers by utilizing responses captured in the annual CAHPS survey for Commercial, Marketplace/QHP and Medicare members; recording and following up on member complaints and appeals regarding access to specialty care; compiling requests for and utilization of out-of-network data; and by conducting telephone surveys to ensure appointments are available to Members.

The following are the CAHPS questions related to specialist appointment access are utilized in this standard:

- Commercial – (Q20) “In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?”
- Marketplace/ACA – (Q39) “In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?”

Rates for requests and appeals related to out of network providers per 1000 members for each year are determined by dividing the number of requests, claims, complaint and appeals for the year by the total number of members and multiplying by 1000.

The specialty care physician appointment access standards, measurement method, and measurement frequency for each aspect of performance that is monitored is listed in the table below:

Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
OB/GYN new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	Office appointment access survey	Annually
OB/GYN established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Office appointment access survey	Annually
OB/GYN new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	Office appointment access survey	Annually

Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
OB/GYN established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	Office appointment access survey	Annually
Medical Oncology new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	Office appointment access survey	Annually
Medical Oncology established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Office appointment access survey	Annually
Medical Oncology new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	Office appointment access survey	Annually
Medical Oncology established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	Office appointment access survey	Annually
Radiation Oncology new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	Office appointment access survey	Annually
Radiation Oncology established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Office appointment access survey	Annually
Radiation Oncology new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	Office appointment access survey	Annually

Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Radiation Oncology established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	Office appointment access survey	Annually
Complaints	Rate of member complaints about appointment access is less than 0.5 per 1000 members	Complaint analysis	Annually
Appeals	Rate of member appeals about appointment access is less than 0.5 per 1000 members	Appeal analysis	Annually
Specialty appointments	At least 80% of members report they always or usually obtained appointments as soon as they needed	CAHPS member satisfaction survey	Annually
Requests for Out of Network Specialty Care	Rate of requests for HMO members to be referred to out of network specialty providers is less than 25 per 1000 members	Referral analysis	Annually
Utilization of Out of Network Specialty Care	Utilization for HMO members of out of network specialty providers is less than 50 per 1000 members	Claims analysis	Annually

Specific FHCP Policies and Procedures related to this topic include:
PC030: Provision of Health Care Services
PC032: Provider Network Availability & Access Monitoring and Improvement Process

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HOW TO JOIN OUR NETWORKS

FHCP has several networks available to licensed providers that meet our contracting criteria and network needs. Participation in one network does not automatically mean that the provider participates in every network. Each network may correlate to multiple products; refer to your FHCP provider Agreement to

confirm your network participation.

Providers participating in our networks are reimbursed based on the terms of their Agreement for services to eligible members and have agreed to accept the FHCP allowed amount (less deductibles, coinsurance, and/or copayments) as payment-in-full for covered services. When members access participating providers, covered benefits are typically reimbursed at a higher benefit level, and their out-of- pocket costs are usually lower.

Physicians and providers are selected to participate in our networks based on an assessment and determination of the network's needs. To be considered for participation you must send us your request to participate in our Networks. Your request must be submitted in writing to: FHCPProviderRelations5@fhcp.com.

Your participation request should include

- the names of all practitioners or facilities to be included in our network,
- the specialties/services you propose to offer FHCP members,
- locations and hours of all offices, and
- contact information that can be used by FHCP to respond to your participation request.
- Federal Tax ID Number and copy of current W9 form
- If provider participates in a Florida Blue Network, include your Florida Blue Provider number

Some of our provider networks may be closed or open only in limited areas. The link to FHCP's Network access standards is noted on page 4. Your request will be reviewed and submitted to the FHCP Contract Committee for consideration. If your participation request is declined, unless we inform you otherwise, you may check back with us periodically as we are constantly evaluating our networks' needs.

The Credentialing Process

The verification of credentials is an integral part of our network process. It helps ensure our members have access to quality care and it is also required to meet both state and federal guidelines. Completion and submission of the application and the required documentation does not guarantee inclusion in any of our network(s).

Providers requesting initial credentialing or recredentialing to the medical staff or a FHCP Network undergo the credentialing process as established by the Governing Body of FHCP, as set forth in the FHCP medical staff by-laws, rules and regulations.

The credentialing process is completed before any contract becomes effective or any provider begins to see or treat FHCP members. When FHCP identifies the need to contract with a provider or when coverage or other arrangements are necessary to make a practitioner's services available to FHCP members, it then becomes necessary to initiate credentialing of the provider.

The following practitioner types are credentialed by FHCP:

Physicians:

- MD's
- DO's
- Dentists (DDS, DMD) providing medical benefit services (ex. TMJ, Sleep Apnea)

- Dentists (DDS, DMD) who render services that are covered by Medicare
- Oral Surgeons (MD, DDS, DMD)
- Podiatrists (DPM)
- Chiropractors
- Optometrists

Behavioral health care practitioners:
- Doctoral or Master's Level Clinical Psychologists
- Master's Level Clinical Social Workers
- Licensed Mental Health Therapists
- Behavior Analysts practicing independently

Practitioners who are hospital-based but are credentialed because of an independent relationship with FHCP:
- Anesthesiologists with pain-management practices
- Hospital-based practitioners who are directly employed by FHCP

Non-Physician Practitioners that have an independent relationship with FHCP:
- Nurse Midwives
- Physical Therapists practicing independently
- Physician Assistants
- Nurse Practitioners practicing independently

The following are also credentialed when directly employed by FHCP:
- Physician Assistants
- Nurse Practitioners
- General Dentists

Telemedicine providers, including out-of-state physicians who are properly registered with the Florida Department of Health Facilities:
- Hospitals
- Ambulatory Surgery Centers
- Clinical Laboratories
- Community Mental Health Centers
- Dialysis Centers
- Freestanding Psychiatric Hospitals
- Home Health Agencies
- Hospice
- Outpatient Rehabilitation Centers
- Physical Therapy Centers
- Residential and Ambulatory Addiction Treatment Facilities
- Skilled Nursing Facilities
- Urgent Care Centers
- Audiology/Hearing Aid Clinics
- Birthing Centers
- Portable Imaging Providers

Note: Participating hospital-based physicians who practice exclusively in the hospital, skilled nursing facility and/or ambulatory service center settings are required to meet FHCP's 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 as long as 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.

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 request for closure or termination of your contracts. Providers have the right to obtain status of their application and information shared with Practitioners may include information obtained to evaluate their credentialing application, attestation or curriculum vita.

Awaiting an Answer

Completed applications are verified and a decision is made for participation with FHCP. Each applicant will receive a written response regarding contracting status.

The following are circumstances which will delay your answer:

- Incomplete credentialing applications
- Missing application signatures
- Incomplete credentialing documentation
- Expired documentation

Note: If you have completed and submitted all required documentation and haven't received any communication within 90-days, you may contact our Provider Services department who can help you with the process.

Specific FHCP Policies and Procedures related to this topic:

PC014: Contract Determinations and Appeals
LD002: FHCP Medical Staff Bylaws, Rules and Regulations

We will provide you with notice of any changes and display needed information via updates to this Guide. Updates can be viewed in the "Provider Education" section of our website at https://www.fhcp.com/for-providers/. The current version of the above applicable FHCP policies and procedures are available upon request by contacting the FHCP Provider Services Department at 386-615-5096 or 1-800-352-9824, Opt 1 + 5096. Requests can also be made via email to FHCPProviderRelations5@fhcp.com.

FHCP PARTICIPATING PROVIDER RESPONSIBILITIES

Provider Data and Demographics Maintenance

This section of the Manual outlines various processes for reviewing and maintaining your Provider Data record at FHCP.

Participating Providers should conduct business with us electronically through the FHCP Provider Portal. To use our self-service tools, you need only register with FHCP and define your users, in addition to yourself. When you register for the FHCP Provider Portal, you will be given the *Administrator* role, or you can designate someone within your practice or facility to be the FHCP Portal Administrator for your practice. The administrator can perform all portal functions (including receiving notifications related to your data). Your portal administrator may also register additional users. We are serious about protecting your data and have additional security around the ability to view and update your records. Your administrator has access to this. Refer to the FHCP Provider Portal User Guide for additional information about the FHCP Provider Portal.

Proactive and Timely Update of Your Provider Records

As you know, provider demographic data is at the core of doing business with you. It impacts claim payments (timeliness and accuracy), our provider directories (how our members find you), and how you request and receive referrals and authorizations for the care of your patients (our members).

FHCP providers are contractually required to report all changes of address or other practice information electronically. Providers must notify us 30-days prior to the effective date of any changes to ensure accurate information is displayed on the provider directory and to avoid impacts to claims processing.

You must review and validate your information as it appears in FHCP's online provider directory no less than quarterly, as required by the Centers for Medicare & Medicare Services (CMS). CMS now requires quarterly validation of participating provider information. Make sure we have your correct address, telephone number, email address and ability to accept new patients (see below).

The key demographic content (see below) must be reviewed and validated quarterly. FHCP is to be made aware of the following practice changes:

- Practice Name
- New ownership, change in contract affiliation, or change in tax ID number/billing address
- New providers joining the practice
- Providers leaving the practice
- Covering physicians
- Change in hospital or ASC affiliation
- Languages spoken (by office and physician)
- Medicare participation status (if applicable)
- Email address of practice manager and website URL for the practice
- Demographic changes for each provider (including addition of new locations):
- Address
- Phone #
- Fax #
- Accepting new patients or panel closure notification

- Ages of patient acceptance
- If facility, hours of operation

Register for and use the FHCP Online Provider Portal

To use our self-service tools, you need only register with the FHCP Provider Portal at www.fhcp.com It is recommended that your Practice Manager or other designee register first as they will automatically be assigned the role of Local Administrator and responsible for creating, maintaining and disabling user accounts for your practice. When utilizing the Provider Portal, you will be able to view benefits and eligibility on your patients and view claim and authorization status. The portal also gives you the option to send notifications when your practice information has changed! We are serious about protecting your data and have additional security around the ability to view and update your records.

Participate in FHCP's Annual Provider Survey

FHCP's Provider Survey is performed annually. We strongly advise all participating providers to complete this survey and return it to FHCP in a timely manner. Survey questions cover both the Provider's experience with FHCP and its networks, departments and service systems as well as how FHCP compares to other insurance companies in areas such as the quality of care and services provided and ease of working with the Plan. Results are trended year over year to allow for continued trending of Provider responses compared to past years. Survey questions also assist in review of the quality of communications between practitioners each year.

FHCP endeavors to supply Providers with an additional way to communicate any concerns of discrimination pertaining to Medical Staff membership via the survey with the question "Have you ever felt that you were granted or denied Medical Staff membership solely on the basis of age, sex, sexual orientation, race, creed, color, religion, national origin, disability or any other legally protected status?"

FHCP displays survey results for each Network segment based on demographics and referral patterns. Volusia County's Network is divided into three segments to better reflect the distinct geographic regions. (East, Southeast, and West).

Each year, the FHCP Contracting Committee establishes a performance benchmark as the minimum acceptable response for each survey question in the Provider Survey. Areas scoring below this benchmark, or those which scored lower in the current year when compared with the previous year's scores for all networks by more than 0.2 are targeted by the Committee as those which FHCP should focus its performance improvement efforts for the coming year.

Individual Provider comments included on returned surveys have provided useful insight as to the basis of Provider scores in various areas. Responses and recommendations based upon this input will be incorporated into the Performance Improvement Committee's corrective action plan. Recommendations from the Committee will then be forwarded to FHCP's Governing Body.

A copy of the most recent Provider Survey, supporting charts, and data tables are reported reflecting submitted survey data which compare the results from the current year and the previous five years Provider Surveys accordingly.

The results of each year's Provider Survey will be posted on the FHCP web site at www.fhcp.com and in the Provider Portal for access by Providers for review. A link to the current Survey report is included in the "Frequently Referenced Sections" at the beginning of this Manual.

Additional Provider Responsibilities

We offer a variety of product lines to meet the health care coverage needs of our members. Each product at FHCP corresponds to one or more networks. Below are "highlights" of responsibilities generally associated with our provider agreements; this listing is not all-inclusive.

- Provide covered services to members with FHCP coverage.
- Do not discriminate against any member on the basis of race, color, religion, sex, national origin, age, and health status, participation in any governmental program, source of payment, marital status, sexual orientation, including gender identity or physical or mental handicap. (See additional information under 'Importance Notice' below.)
- Provide our members, your patients, timely care based on their health care needs as outlined in your FHCP Agreement.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Agreement (which includes the most current manual).
- Accept payment, plus the member's applicable deductible, coinsurance and/or copayment, as payment-in-full for covered services.
- Provider does not balance bill the member for any differences between the charge and the contractual allowance for covered services**.** The member is only responsible for any applicable deductible, coinsurance, and/or copayment and non-covered service amounts or services exceeding any benefit limitations.
- Comply fully with our Quality Improvement, Utilization Management program, Case Management, Disease Management and Focused Illness/Wellness, and Audit Programs.
- Cooperate with the FHCP's QI activities to improve the quality of care and services, as well as member experience. Cooperation includes collection and evaluation of data and participation FHCP's QI programs. FHCP may use practitioner performance data for quality improvement activities.
- Adhere to FHCP business ethics, integrity and compliance principles and standards of conduct.
- Participate in annual Provider Surveys
- Promptly notify us of claims processing payment errors.
- Maintain all records required by law regarding services rendered for the applicable period of time. 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.
- Comply with all applicable federal, state, and local laws and regulations.
- Maintain liability insurance in the amount required by the terms of your Agreement.
- Notify us of the intent to terminate your Agreement as a participating provider within the Member timeframe specified in your Agreement.
- Notify us timely when there is a change to your practice. Be it addition or removal of medical staff, ownership changes or address, telephone and fax changes your contract requires notice and CMS requires accuracy in all provider directories. These updates may be sent to FHCPProviderRelations5@fhcp.com.

Important Notice Regarding Final Regulations on ACA Nondiscrimination Rules (Section 1557) Effective July 18, 2016

- The Office of Civil Rights (OCR) and the Department of Health & Human Services (HHS) issued final regulations on May 18, 2016 finalizing Section 1557 of the Affordable Care Act (ACA). The final rule prohibits "covered entities" from discriminating on the basis of race, color, national origin, sex, age and disability

and provides examples, including a prohibition on categorical exclusions or limitations on all health services related to gender transition. It incorporates many long-standing civil rights and discrimination laws that have been in place for decades (including their regulations and outcomes of thousands of lawsuits). While there are multiple federal non-discrimination laws, this final rule clarifies the prohibition of discrimination in the health care and benefits setting. The rules apply to any carrier, employer sponsored plan, or provider who receives federal financial assistance or funding from HHS and carriers who participate in the Federally-Facilitated Marketplace, Medicare Advantage, or Medicaid.

Providers should post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services.

- Providers should post taglines in the top 15 languages spoken by individuals with limited English proficiency in that state and indicate the availability of language assistance.
- Translated Resources are available on the Health & Human Services website (https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated- resources/index.html).
- Providers should take appropriate steps to ensure that communications with individuals with disabilities are as effective as communication with others.
- Providers should provide appropriate auxiliary aids and services, such as alternative formats and sign language interpreters, where necessary for effective communication.

Confidentiality of Member 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 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 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 common areas 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 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.

ROLE OF PRIMARY CARE PHYSICIAN (PCP)

Definition

A Primary Care Physician (PPCP) provides or manages first contact, continuous and comprehensive health care services for a specific group of patients who have selected the physician as their principal health care provider. Primary Care Physicians (PCP's) are usually generalist physicians, board eligible or board certified in family medicine, internal medicine or pediatrics. The PCP is the key medical person coordinating the patient's health care and is responsible for, but not limited to, the following:

- A clinical focus on health promotion and disease prevention. The PCP will be knowledgeable and supportive of the organizational guidelines for preventative and disease-oriented care.
- Twenty-four (24) hours a day and 7 days a week on-call availability within a coverage group of other FHCP participating physicians.
- Timely availability for ambulatory visits and calls at various levels of service (emergent, urgent, routine, symptomatic, and routine non-symptomatic) including health maintenance, as well as, symptom related care.
- Involvement in all urgent and emergent clinical events.
- Provide annual medical exams and other preventative health services as indicated.
- Management and coordination of the use of ambulatory consultant services and diagnostic testing.
- Support and involvement in all acute inpatient care.
- Maintaining admitting privileges and active medical staff membership with the FHCP Medical Staff and at least one FHCP participating hospital unless otherwise covered by a Hospitalist admitting team per contract.
- Support and involvement in Performance Improvement activities with a goal of improving the quality and reducing the cost of care.
- Facilitating communication with the patient and FHCP.

Selection of the Primary Care Physician (PCP)

At enrollment, each HMO member is required to select a Primary Care Physician (PCP) from the list of FHCP participating providers. Each new enrollee is instructed to view information regarding participating PCP's on the FHCP website. The member is instructed to either use the Member Portal to initially select or change their PCP. Or the member may call the FHCP Member Services Department and select a PCP before attempting to schedule an appointment. When members call Member Services, their selection is recorded and entered into the FHCP system, and the PCP can verify their assignment to their panel using the online Provider Portal. FHCP encourages each new member to contact his/her PCP and to become established with the PCP's practice.

Updates of member additions and deletions are provided via the Provider Portal throughout the month. Members may appear on provider's PCP Panel who are new to the physician and who have not yet established themselves as patients within the physician's practice. Occasionally, members may require urgent or emergent care from their PCP prior to scheduling an initial appointment. The PCP is expected to accommodate the member's request to be seen on an urgent basis, even if the member is not an established patient, and to care for the patient in the hospital if the PCP has admitting privileges.

If a FHCP staff PCP wants a FHCP member deleted from his/her panel, the Request for Primary Care Provider Change form must be completed with specific detail on the reason for the request and forwarded to the Physician Assignment Office. The request will be reviewed by the Administrator of Quality Management who will work with the physician to make an appropriate plan of care for the patient.

If a FHCP contracted PCP wants a FHCP member removed from his/her panel, the practice should follow their office policy for discharging patients from their panel. Once FHCP receives the removal

notice from the practice, FHCP will send a letter to the member instructing them how to select another provider for their care.

PRIMARY CARE PHYSICIAN (PCP) Panel Management

Each Member and potential member shall have access to FHCP's Online Provider Directory and instructions as to how to select a PCP to coordinate their Health Care Services.

The Provider Access Specialist (PAS) shall maintain PCP Panel limits in the FHCP computer system and monitor appropriate assignment of Members to PCP's based on contractual requirements. The PAS shall advise appropriate FHCP personnel concerning the status of PCP panels as to those PCP's accepting additional Members on their respective panels via a spreadsheet that is disseminated to the Member Services Department and the Provider Services Department.

PCP Assignment Change Requested by a FHCP Member

If a Member chooses a PCP and later wishes to change practitioners, the Member is permitted to do so at any time. The Member may change their PCP via a telephone call to FHCP's Member Services Department, via written request, or via one contact to FHCP's internet-based Member Portal application. The Member's change request will be confirmed in writing by the PAS, or via automated response in the Member Portal application. The exceptions to this policy include:

- A Member who exhibits unacceptable behavior in the physician's office or to the physician or his/her staff. This behavior must have prompted the creation of an Adverse Occurrence Report that is documented by the PCP for review by the FHCP Quality Management Division.
- A significant extenuating circumstance approved by the President/Chief Medical Offices and Chief Executive Officer.

Primary Care Physician Coverage

Outpatient Coverage
The PCP shall provide outpatient coverage for all members assigned to the Provider Panel twenty-four (24) hours per day, seven (7) days per week. In the event the Provider enters into agreement(s) with other physicians for purposes of sharing said responsibility, Provider agrees to have such physician(s) sign the FHCP "Covering Physician Agreement" as applicable.

Inpatient Service Coverage
FHCP Hospitalists shall provide hospital call coverage services and appropriately follow all FHCP members assigned to the Provider Panel. FHCP Hospitalists shall be responsible for covering primary care call with respect to those FHCP patients assigned to Provider's panel, twenty-four (24) hours a day, seven (7) days per week, for the inpatient facilities herein designated for all FHCP members. Should Provider elect to discontinue use of Hospitalist call coverage, Provider shall notify FHCP in writing at least thirty (30) days prior to said change. Also, if Provider is being paid based on capitation FHCP's capitation payment to Provider shall be adjusted as described in applicable capitation table.

PARTICIPATING PROVIDER COMPLIANCE WITH STATE AND FEDERAL REGULATIONS

The health care environment has become increasingly complex with hundreds of new and existing Federal and State regulations currently in effect and new technologies changing the way we conduct our business. In addition, numerous threats to our resources have been identified. To position ourselves to confront these issues effectively, FHCP has developed a program titled “Our Values in Action” that outlines these issues and sets forth a framework within which they can be addressed.

Initially, FHCP created a program for its staff that included a Compliance Plan, Code of Conduct, and Anti-Fraud Plan. Every new and existing FHCP employee receives a copy of the handbook and training that outlines this program. It is a condition of employment at FHCP that all staff conducts themselves in a manner consistent with this program.

Subsequently, FHCP seeks to encourage our contracted providers to develop and implement similar programs. Contained in this guide is information intended to assist all FHCP contracted healthcare providers with developing effective compliance programs that will reduce the likelihood of behavior inconsistent with the realities of today’s healthcare landscape. Compliance Plan guidance is outlined on the pages that follow.

More recently, and in accordance with the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage-Part D Plans must ensure that all of their contracted providers and their staff are appropriately trained regarding the prevention and detection of fraud, waste & abuse (FWA). To assist your organization in meeting this requirement, FHCP has created Fraud, Waste, & Abuse and General Compliance training materials with an attestation of completion that can be found on our website at www.fhcp.com. You can also access the document directly by copying the following link into your browser:

https://www.fhcp.com/for-providers/

Please note that contracted providers and related entities that have met the fraud, waste, and abuse certification requirement through enrollment into the Medicare program are deemed to have met the training and education requirements for fraud, waste, and abuse.

FHCP requires that all of its providers conduct themselves and their practices in an ethical and lawful manner. We strongly encourage all of our contracted providers to develop programs appropriate for their settings that reduce the likelihood inappropriate conduct.

Please return completed attestations to: FHCP Government Relations and Compliance Unit.

Compliance Plan Guidance

The U.S. Department of Health and Human Services' Office of the Inspector General has developed Compliance Plan guidance for a number of different health care provider types. These guidelines can be accessed via the Internet at:

https://oig.hhs.gov/compliance/compliance-guidance/index.asp

In general, each compliance plan should contain the following seven elements:

1) **Policies and Standards -** An organization must have established standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of inappropriate conduct.
2) **Oversight Responsibility -** Specific individual(s) within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures.
3) **Training, Education & Communications -** The organization must have taken steps to effectively communicate its standards and procedures to all employees and other agents, i.e., by requiring participation in training plans or by disseminating publications that explain in a practical manner what is required.
4) **Effective Lines of Communication -** The organization must maintain an effective line of communication between employees and the individual responsible for overseeing compliance with applicable standards and policies.
5) **Enforcement & Discipline -** The organization must have in place standards that ensure the plan is consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense. Adequate discipline of individuals responsible for an offense is a necessary component of enforcement; however, the form of discipline that will be appropriate will be case specific.
6) **Auditing, Monitoring, and Reporting -** The organization must take reasonable steps to achieve compliance with its standards. Such steps should take the form of monitoring and auditing systems reasonably designed to detect inappropriate conduct by its employees and other agents, and by having in place and publicizing a reporting system whereby employees and other agents could report inappropriate conduct by others within the organization without fear of retribution.
7) **Response and Corrective Action -** The organization must have in place a mechanism by which the organization will respond to detected offenses and prevent further similar offenses - including any necessary modifications to its plan to prevent and detect violations of law.

Fraud, Waste, and Abuse (FWA) Training Guidance

FWA training programs should include:

- Laws and regulations related to MA and Part D fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.).
- Obligations of the first tier, downstream, and related entities (FDR's) to have appropriate policies and procedures to address fraud, waste and abuse.
- Process for reporting to the MAO or PDP sponsor suspected fraud, waste and abuse in first tier, downstream, and related entities.
- Protections for employees of first tier, downstream, and related entities who report suspected fraud, waste and abuse.
- Types of fraud, waste and abuse that can occur in first tier, downstream, and related entities.
- Compliance program guidance, required elements, and descriptions.

Please access the General Compliance and Fraud, Waste, and Abuse (FWA) documents for contracted providers and staff for education and training on our website at www.fhcp.com. You can also access the documents directly by pasting the following link into your browser:

https://www.fhcp.com/for-providers/

How to Report Violations

In the event that you identify or become aware of an activity that is not in accordance with applicable standards, whether committed by your organization or another, you are encouraged to report the act to:

Government Relations and Compliance Unit
Florida Health Care Plans
1340 Ridgewood Avenue Holly
Hill, FL 32117 (386) 615-4080

HIPAA Privacy Policy Summary:

RR007 – **General Privacy Policy:**

- Summary of all FHCP Privacy Policies
- Standards
- Effective Dates

RR008 – **Uses and Disclosures of Protected Health Information:**

It is the policy of FHCP to only use and disclose protected health information (which includes all demographic, medical or other information in which there is a reasonable basis to believe could be used to identify the individual) that it creates on its members/patients as allowed by law, rule, or regulation to deliver the services purchased by the individual. FHCP may use and disclose Personal Health Information (PHI) without an authorization for:

- Treatment
- Payment
- Healthcare Operations
- As required by law

RR009 – **Individual Right to Notice of Privacy Practices:**

Beginning April 14, 2003, FHCP made available to each of its members/patients the organization's Notice of Privacy Practices. Such Notices were mailed to all existing policyholders and made available to all other members/patients at point of service, such as clinical suites. The Notice of Privacy Practices is also available on-line at: www.fhcp.com. Staff encountering members/patients with questions about the Notice should refer them to the member Services Department.

RR010 – **Privacy Safeguards:**

It is the policy of FHCP to implement appropriate administrative, technical and physical safeguards to protect medical information from unintended or unauthorized use, disclosure, modification, or loss. Additional standards applicable to the safeguarding of our member/patients PHI can be found in MIS002-MIS021 policies.

RR011 – **Accounting for Uses and Disclosures of Medical Information (AOD):**

It is the policy of FHCP to, upon request; provide to its members/patients an accounting of uses and disclosures of his/her medical information. Such accounting shall include all disclosures other than those made for treatment, payment, or healthcare operations purposes or disclosure authorized by the member/patient. Requests for an AOD should be forwarded to FHCP's Government Relations and Compliance Unit in FHCP's Holly Hill facility.

RR012 – **Individual's Right to Access and Request Amendment/Restriction to His/Her Medical Information:** Every FHCP member/patient has the right to inspect and obtain a copy of their medical information. There is a fee for accessing and a fee for obtaining a copy of a medical record. Additionally, members/patients may request an amendment to their medical information. Any FHCP staff that encounters a member/patient who wishes to inspect, obtain a copy of or request an amendment to their medical information should refer the member/patient to FHCP's Medical Records Department.

RR015 - Breach Notification Requirements for Unsecured Protected Health Information: It is the policy of FHCP to comply with Section 13402 of the Health Information Technology Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009 (ARRA), CFR 45, Parts 160 and 164 as it applies to providing notification in the event of breaches of unsecured protected health information by HIPAA covered entities and their business associates who access, maintain, retain, modify, record, store, destroy, or otherwise hold, use, or disclose unsecured protected health information.

RR016 – Member Rights to Health Plan Information (VIEWING ELECTRONIC PHI):
Those individuals (users) that are granted access rights to FHCP's information systems that house electronic PHI must adhere to the following:

- Users may view their own PHI.
- Users are prohibited from viewing information pertaining to any minor or emancipated minor.
- A user may (only) view the information of any adult for whom the user has been properly authorized in accordance with MR005-Section I, written requests for medical record information, of this policy. The user must refrain from contacting the individual's physician regarding any information that the user viewed and allow the physician to initiate communication, if required, with the individual.

MR005 - Release and Revocation of Release of Protected Health Information (PHI): Medical records are maintained by (FHCP) for the benefit of the patient, the practitioner, and FHCP and are the property of FHCP. The Protected Health Information (PHI) in the record remains privileged and may NOT be used or disclosed without proper authorization except as allowed by law. For the purposes of this policy, the term medical records information includes information that is communicated on paper, via electronic means or verbally.

We will provide you with notice of any changes and display needed information via updates to this Guide. Updates can be viewed in the "Provider Education" section of our website at https://www.fhcp.com/for-providers/. The current version of the above applicable FHCP policies and procedures are available upon request by contacting the FHCP Provider Services Department at 386-615-5096 or 1-800-352-9824, Opt. 1 + 5096. Requests can also be made via email to FHCPProviderRelations5@fhcp.com.

RISK MANAGEMENT

Purpose of Risk Management

- Prevention – Early detection of any possible areas of risk helps the organization prevent accidents and injury. Early reporting of potential medical errors is necessary for prevention.
- Improvement – Doing things better, whether it is a service, a process, or a product. Improving how we provide services to patients helps us improve the health of the community and reduces the organization's financial risk.
- Compliance and Regulations – Regulatory agencies have standards for quality improvement and safety within our facilities. These standards require a Risk Management program to minimize the risk of injury and adverse incidents to patients.
- Benefits – By identifying and reducing risk, we maintain a safe environment. This benefits patients, visitors, employees, the organization and the community.

What is Considered a Reportable Adverse Event?

A reportable event is any happening outside of the usual, routine, normal, customary or ordinary activities of the organization, including but not limited to:

- Member, visitor, staff, volunteer or student injuries
- Medication or treatment variances
- Damage, theft, or loss of facility property
- An event that did not reach the patient, but could have if the risk had not been
- identified (also known as a "near miss")
- Adverse drug reactions
- Physical or verbal abuse of a member
- Delay in care

Reporting Adverse Events

All events should be reported using the electronic occurrence reporting system. Events are NEVER submitted by a paper or via email. If you are a participating provider and do not have access to the reporting system, please contact Risk Management at extension 5042 or 5104.
For FHCP Employees: The link for the electronic reporting system is: http://ems.fhcp.local/EMS_PROD/.

- To report an event in FHCP's Risk Management System: Open Google Chrome – The B.E.A.C.H. will appear. Choose "Favorites", then "EMS". This will take you to the IDinc program. Also, from The B.E.A.C.H. page you can utilize the FHCP Bookmarks in the upper left corner and then scroll down to "Report an Incident."

- Be sure to include all essential information, such as the identity of the person involved in the incident, the exact time and place of the incident and the name of the doctor you notified.
- Be sure to document any unusual occurrences that you witnessed.
- Record the events and the consequences for the patient in enough detail that Risk Management can decide whether or not to investigate further.
- Write objectively, avoiding opinions, judgments, conclusions or assumptions about whom or what caused the incident. Tell your opinions to your supervisor later.
- Describe what you saw and heard along with any actions taken by you at the scene. Example: Unless you saw a patient fall, write "found patient lying on the floor."
- Do not offer suggestions in the event reporting system about how to prevent the incident from happening again in the future. That is normally part of the investigative follow-up.
- Do not admit that you are at fault or blame someone else.
- Do not include detailed statements from witnesses and descriptions of remedial action, as these are normally part of an investigative follow-up.

- Do not place documentation in the medical record than an incident report was completed.
- If needed, there is an instructional video on the first page of the electronic incident reporting system.

Code 15

Code 15 incidents are defined as an adverse event, whether occurring in the facility or arising from healthcare delivered prior to admission to our facilities, in which healthcare personnel could exercise control; or that which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred.

A Code 15 event is an unexpected event involving death or serious physical injury. It specifically includes:
- The loss of limb, or function
- Medication errors that results in death, paralysis, coma or major loss of function
- Inpatient suicide, or suicide following elopement from an inpatient setting
- Surgery performed on the wrong patient, wrong side of the body or wrong organ
- Infant abduction or a discharge to the wrong family
- Sexual assault, homicide, or assault resulting in death or major permanent loss of function
- Fall that results in death or major permanent loss of function
- Blood transfusion reactions involving blood incompatibilities
- Infections resulting in death
- Surgical fires

Under Florida Law, these events are required to be reported to AHCA (Agency for Healthcare Administration) within 3 business days with a follow-up investigation report within 15 days of the event occurrence.

Contacting the Risk Manager after hours
Risk Management should be notified at extension 5042 or 5104 during normal business hours and through the Call Center at (386) 254-4242 after hours and on weekends in the event of a serious event:
- Any event resulting in death
- Any event deemed urgent by staff
- Any other incident that may present significant public embarrassment to the organization.

Abuse/Misconduct Reporting Policy

Every instance of known, suspected or alleged abuse occurring within the facility or on facility grounds, including all locations, or prior to the patient's arrival, shall be reported to the Risk Management by the quickest means available.

Sexual abuse is defined as an act of a sexual nature committed for the sexual gratification of anyone upon or in the presence of a vulnerable adult, without the vulnerable adult's informed consent, or upon a minor.

A vulnerable adult is defined as a person 18 years or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to mental, emotional, physical, or developmental disability or disjunction, or brain damage, or the infirmities of aging.

Sexual misconduct or abuse includes but is not limited to:
- Acts of fondling
- Exposure of a vulnerable adult or minor's sexual organs
- The use of a vulnerable adult or minor to solicit or engage in prostitution or sexual performance

OUR PRODUCTS

Commercial and Individual Under 65 Products

FHCP offers a variety of products with network configurations to meet our member needs for coordination of care and greater affordability. We have a variety of products for individuals, small groups, and large groups on a fully insured and self-funded basis. These products may or may not require members to select a Primary Care Physician (PCP), may or may not have out-of-network benefits and may include broad or narrow network of participating providers.

Our products and services are continually evolving to ensure we stay true to our mission, to provide FHCP members with health care and related services through dedicated employees and service partners who manage both the quality and cost of health care. Coverage can also be purchased through the individual or small group Health Insurance Marketplaces.

Visit www.FHCP.com for more information about our non-Medicare products in your area. If a member presents an identification card (ID) with a product name with which you are not familiar, please contact our Data Integrity Department for assistance.

We are committed to offering quality health care coverage, as well as maintaining the dignity and integrity of our members, we do not discriminate against members based on race, sex, color, creed, national origin, gender, sexual orientation, gender identity, age, disability or marital status.

Medicare Products

FHCP administers FHCP Medicare products under arrangement with Blue Cross Blue Shield of Florida, Inc. (Florida Blue). Florida Blue operates as a Medicare Advantage (MA) Organization. All FHCP Medicare products are a Health Maintenance Organization (HMO) line of business. FHCP Medicare offers Medicare Advantage HMO products that include prescription drug coverage in select Florida counties. Please access our website at www.FHCPMedicare.com for more information on our Medicare products and service area.

Note: All FHCP Medicare members must select a Primary Care Physician upon enrollment. A notification of a referral from a Primary Care Physician is required for ALL FHCP Medicare HMO products when the member requires treatment from specialists, including all ophthalmologists, except for dentists, mental health and substance abuse providers, podiatrists, dermatologists, dialysis, chiropractors, women's health specialists for routine and preventive services, and urgent and emergency care providers.

As a MA Organization, we must comply with applicable federal and state statutes, regulations, and policies. In turn, a provider contracting with us to furnish services to Medicare Advantage members must comply with applicable federal and state statutes, regulations and requirements, and our policies and procedures. For example, FHCP must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in a FHCP MA plan who has not signed a private contract with a beneficiary, but FHCP may not otherwise pay opt-out providers. Members are responsible for such payments for non-emergency services rendered by opt-out providers.

When a Medicare beneficiary enrolls in a Medicare Advantage plan, it takes the place of Original Medicare benefits. Medicare Advantage members receive a document called the Medicare Advantage Evidence of Coverage (EOC). It explains the covered services and defines the rights and responsibilities of the member and FHCP Medicare.

For those services covered by FHCP MA plans, MA members are responsible for copayments, and deductibles and coinsurance (if applicable) only. Medicare providers may not balance bill qualified Medicare beneficiaries for Medicare cost share amounts. The member's ID card will indicate the product name and display

the words "Medicare Advantage HMO".

Global Coverage Plan for International Travel

As an affiliate of Florida Blue, all FHCP members can access Blue Cross Blue Shield Global™ solutions for international emergency care. Blue Cross Blue Shield Global solutions provide a best-in-class, comprehensive suite of international solutions for people who live, work and travel internationally. Through Blue Cross Blue Shield Global, members can have the confidence that quality care can be accessed wherever and whenever needed. These solutions are available through Florida Blue and GeoBlue, an independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield Global Solutions cover the needs of FHCP Medicare members, U.S. based companies and their mobile employees across the globe for short trips and long-term assignments, giving them the power of Blue, with access to the strongest healthcare network in the U.S. combined with GeoBlue's hand-picked, elite international network – all supported by high-tech, high-touch service.

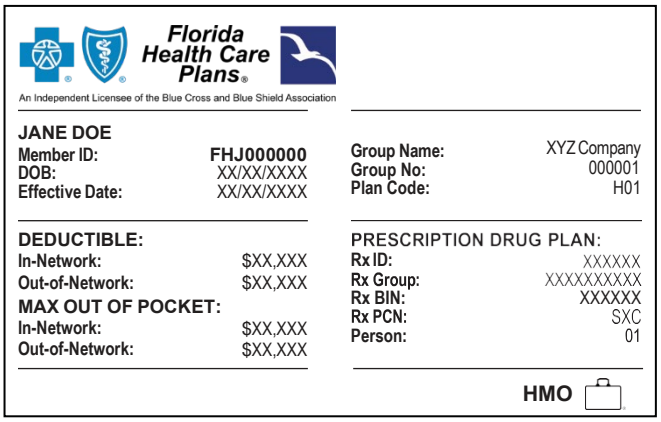
Air Ambulance services are covered only in the United States including those arranged for by Blue Cross Blue Shield Global Solutions.

HEALTH CARE IDENTIFICATION CARDS

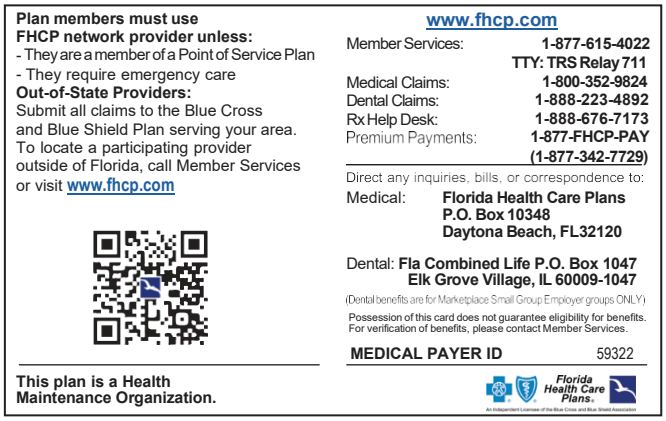
We offer a variety of product lines to meet the health care coverage needs of our members. Presentation of our ID cards in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

Non-Medicare ID Cards

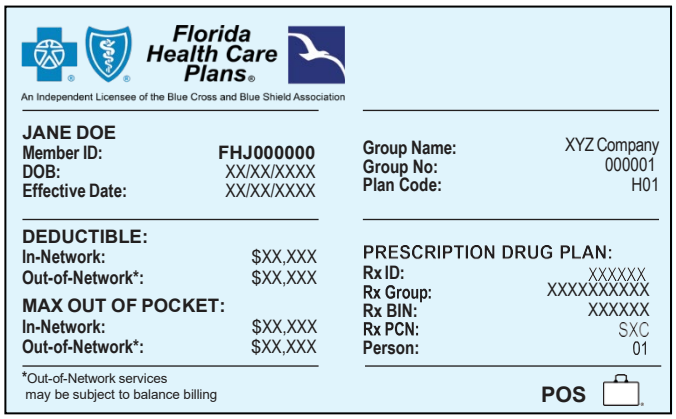
HMO – Card Front



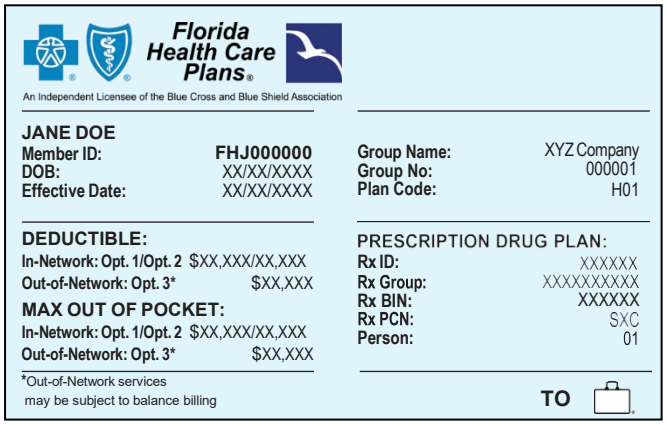
HMO – Card Back



Point of Service (POS) – Card Front



Triple Options (TO) – Card Front



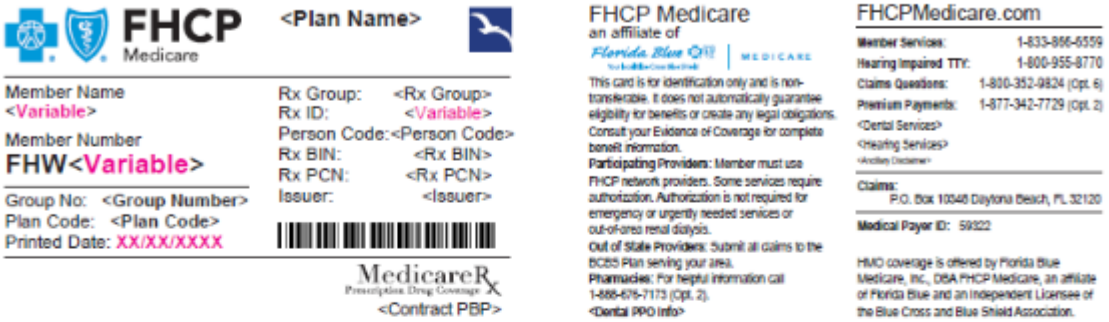
(POS) and (TO) - Card Back

Medicare ID Cards

Medicare ID Card Templates

Medicare Advantage members receive a health care ID card designed to help you access our online systems to verify benefits, eligibility and claim status.

Medicare Advantage Prescription Drug Plans (MA-PD) template



The MA-PD template applies to the following plans

Plan Name	Plan Code	Plan Benefit Package (PBP)
FHCP Medicare Rx Plus	465	002
FHCP Medicare Rx Plus POS	466	002
FHCP Medicare Rx	467	006
FHCP Medicare Rx Savings	468	014
FHCP Medicare Premier Plus	469	011
FHCP Medicare Flagler Advantage	470	016
FHCP Medicare Premier Advantage	471	040

MA-Only template

The MA-Only template applies to the following plan

Plan Name	Plan Code	Plan Benefit Package (PBP)
FHCP Medicare Valor	473	049

FLORIDA HEALTH CARE PLANS MEMBER'S RIGHTS & RESPONSIBILITIES

FHCP Members Have the Right:

- To a reasonable response to your requests and need for treatment or service within FHCP's capacity, and applicable laws and regulations.
- To be informed about, consent to, or refuse recommended treatment.
- To present grievances without compromise to future health care, if you feel these rights have not been provided.
- To file an appeal. Contact FHCP's Member Services Department
- To be considered as an individual with personal values and belief systems, and to be treated with compassion, dignity, respect, reasonable protection from harm, and appropriate privacy.
- To receive quality health care regardless of race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition (including conditions arising out of acts of domestic violence), sexual orientation, sexual identity, claims experience, medical history, evidence of insurability, genetic information, or source of payment.
- To be informed about their diagnoses, treatments, and prognoses. When concern for their health makes it inadvisable to give such information to the member, such information will be made available to an individual designated by the member or to a legally authorized representative.
- To be assured of confidential treatment and disclosure of records and to be afforded an opportunity to approve or refuse the release of such information, except when release is required by law.
- To be informed of what support services are available at no charge to the member, including but not limited to, interpreter services in the language of the member's choice.
- To refuse treatment to the extent permitted by law and be informed of the consequences of their refusal. When refusal of treatment by the member or the member's legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the member may be terminated with reasonable notice.
- To participate in decisions involving their health care, including ethical issues and cultural and spiritual beliefs, unless concern for their health makes this participation detrimental to them.
- To information about FHCP, its providers, practitioners and your member rights and responsibilities.
- To participate in discussions involving medically necessary treatment options regardless of cost and/or benefit coverage.
- To refuse to participate in experimental research.
- To know the name of the physician coordinating their health care and to request a change of their primary care provider.
- To make decisions concerning their medical care, including the right to accept or refuse medical treatment or surgical treatment and the right to formulate advance directives in accordance with the Federal Law

titled “Patient Self-Determination Act” and the Florida Statute Chapter 765 “Health Care Advance Directives.” These rights shall also include the right to appoint a representative either by Power of Attorney or by designation of a Health Care Surrogate to make health care decisions for the member and to provide informed consent if they are incapable of doing so.

- To make recommendations regarding the organization’s member rights and responsibilities policy.
- To bring any person of their choosing to the patient accessible areas of the healthcare facility or provider’s office to accompany them while receiving outpatient treatment or consulting with their health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.

FLORIDA HEALTH CARE PLANS MEMBER'S RESPONSIBILITIES

Members Have the Responsibility:

- To provide accurate and complete information about their present complaints, past illnesses, medications, and unexpected changes in their condition.
- To understand, ask questions, and follow recommended treatment plan(s) to the best of their ability.
- To promptly respond to FHCP’s request for information regarding the member and/or their dependents in relation to covered services.
- To demonstrate respect and consideration towards medical personnel and other members.
- To understand their health problems and to participate in developing mutually agreed upon goals to the best of their ability.
- To know their medicines and take them according to the instructions provided.
- To keep appointments reliably and arrive on time or notify the provider, 24 hours in advance, if the member is unable to keep an appointment.
- To follow safety rules and posted signs.
- To receive all their health care through FHCP, except for emergency care. (Members with a Point of Service or Triple Option Plan should review their “Summary of Benefits and Coverage” Sheet).
- To understand that they are responsible for their actions and consequences, if they refuse treatment or do not follow provider’s instructions.
- To report emergency treatment to FHCP contact Member Services.
- To present their FHCP membership identification card each time they drop off and pick up a prescription.
- To use the emergency room facilities only for medical emergencies and serious accidents.
- To be financially responsible for any co-payments, co-insurance, and/or deductibles and to provide current information concerning their FHCP membership status to the provider.

Estimate of Patient Financial Responsibility

FHCP offers the services of our Cost Estimation Center (CEC) to help providers and members estimate out-of-pocket expenses for a wide range of medical and surgical procedures, before receiving treatment. Providers and members can go online, speak with a Cost Estimation Center Specialist or email the CEC to obtain out of pocket expense estimates based on the member's plan features such as deductible, coinsurance and out-of-pocket maximum.

Providers and members may not realize that the cost for medical services can vary depending on where they are received (i.e. provider participation status for their benefit plan, hospital affiliated vs independent provider). The CEC can help providers and members understand cost options before referring members for care, or prior to members obtaining services by comparing multiple provider costs. The CEC can also help you and your patient better understand and receive FHCP benefits available for Physician Administered Medications.

In addition to the CEC, FHCP offers an interactive Web site that allows members to enter specific information such as medical service descriptions or the AMA's CPT code(s) related to the medical service to obtain estimates of service costs. Please note that such estimates are a range of prices based on local market costs. Member out of pocket costs related to deductibles, maximum out of pocket limits, co-insurance or copayments are not considered in the estimated costs provided by this tool.

For estimated cost information, both providers and members have the following options:

- Go to www.fhcp.com, click [Members] button, select the "About Your Care" option and then select "ESTIMATING YOUR COST" from the list.
- Call the CEC at (386) 615-5068 or toll-free (800) 352-9824, ext. 5068—Monday through Friday, 8am to 5 pm voicemail is available for after-hours or weekend calls.
- Email the CEC at CEC@fhcp.com with inquires and a CEC specialist will respond within 1 business day.

Use of any of the above resources does not constitute FHCP approval or authorization for the service. Actual costs will vary based upon actual services rendered.

It is important to note that FHCP Medicare members who are dually enrolled in Florida Medicaid as a Qualified Beneficiary (QMB) cannot be billed for any Medicare HMO out of pocket expenses. FHCP is prohibited by federal law from paying these expenses as well. Providers should bill the Florida Medicaid program for reimbursement of the QMB patient's financial liability. Please access the link to the MLN Matters information on this topic at the end of this chapter.

HOW WE MANAGE OUR MEMBERS' CARE

Emergency Care

All FHCP members, including FHCP Medicare members, have coverage for medically indicated emergency services worldwide. It is important to note that **emergency Air Ambulance services are covered only in the United States.** Members are encouraged, when possible, to contact and visit their PCP or participating physician when they require medical care. If the physician cannot see the member, the member should be directed to a FHCP network facility or, when appropriate, to the nearest facility. A member is not required to contact a participating physician prior to receiving emergency services and an authorization is not required, whether in or out of the service area. However, an authorization is required for the patient in the event the emergency services result in an inpatient admission.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency care is covered for inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to treat, evaluate or stabilize an emergency medical condition.

Case Management Coordination of Care Department

The Complex Case Management Program targets members with acute or chronic disease(s) including asthma, coronary artery disease (CAD),congestive heart failure (CHF),stroke, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), diabetes, depression (or other behavioral health diagnosis), and organ transplants. Identification of members for participation is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluations the services needed. Members are engaged telephonically and face-to-face.

Criteria for consideration for this program may include members who require any of the following:

- Healthcare related advocacy across the continuum
- Member education
- Assistance with monitoring and treatment
- Assistance with obtaining needed community resources
- Assistance with barriers related to social determinants of health
- Assistance with-behavioral health needs
- Any clinical situation requiring care coordination to enhance continuity of care and quality of life

FHCP has multiple avenues in which a member can be considered for Case Management Services. These include:

- Medical Management Programs, (Central Referrals and Utilization Review)
- Discharge Planning (internal and external sources)
- Member self-referral
- Caregiver referrals
- Data Claims
- New Member Transition of Care Forms
- Health Risk Assessment (HRA)
-

Chronic Complex Care program

The Registered Nurse Care Coordinator provides advocacy and education to help members navigate through the healthcare continuum, access appropriate care, and gain empowerment through self-management of lifestyle practices that can reduce disease progression and complications. The Chronic Complex Care program includes Transplant Case Management from pre-transplantation to one-year post transplant and as needed.

Remote patient monitoring program

The Registered Nurse Care Coordinator monitors the member's daily vital signs and presentation of symptoms through a telehealth system. The program includes daily health sessions to help promote positive behavioral change and self- management skills. Reports to the providers can assist with provision of key insights on the health habits of our members by receiving timely, accurate, and actionable data. Use of this program promotes improved clinical efficiencies, reduced hospitalizations, and improved outcomes for members with chronic conditions. The peripherals offered are scale, blood pressure cuff, pulse oximetry, manual entry of blood sugars from the FHCP glucose monitor.

In-Home Providers-

The In-Home Provider services are implemented through the Case Management Coordination of Care Department. The RN Case Manager evaluates member health conditions, SDOH barriers, and for FHCP contracted in-home providers to address homebound or transitional inpatient setting to home needs. The services supplement primary care services in the home for homebound members with limited support or access to healthcare services and provide transitional care for members discharged from the hospital/skilled facility to home who are at high risk for complications. The goal is to enhance medical and medication management to reduce avoidable emergency room or hospital utilization to help improve quality of life to our members.

Community Resource Program

The Community Resource Coordinator works in partnership with providers/referral sources and members to address the barriers from social determinants of health with the goal to improve access to healthcare related services. The Community Resource Coordinators complete individualized needs assessments and connect members with applicable resources offered through public agencies or within their community. To help reduce financial strain, members are provided financial resources through programs and foundations available to the public, such as the Social Security Administration or Department of Children and Families. The Community Resource Coordinators provide education about public and community services or agencies that may or may not have fees associated.

New Member Transition Process

The Registered Nurse Care Navigator assists new members when transitioning into a new insurance plan to avoid interruption of healthcare. The services consist of a review of the prospective member's care to determine the network participation status of the provider, healthcare services, and the medication formulary. The Transition of Care Nurse Navigator ensure appropriate, cost effective care that provides continuity and coordination of care. The Registered Nurse Navigator assists established members that experience times of transition, including network, plan & formulary changes, member moving to a different service area, and network navigation.

There are various methods to submit a referral for services:
Case Management Coordination of Care or Community Resource Programs

- Telephone Contact: Toll free 855 /205-7293 ext 7288 or 386 /238-3284
- Referral form available through the Provider Resource Guide
- Fax: 386 /238-3271
- Website: www.fhcp.com
- Email: cmanagement@fhcp.com
- Internal: E.H.R. Task

New Member Transition Program

- Direct Telephone Contact 386/615-5017 or Toll free 855/205-7293 ext 5017
- Transition of Care Forms are available through the Provider Resource Guide
  Fax: 386 /238-3271
  Website: www.fhcp.com
- Email: toc@fhcp.com

The Case Management Coordination of Care Department does not substitute for urgent evaluation or intervention by their healthcare providers; replace home health care or emergent staffing, in home safety evaluations; skilled placement; or emergency evaluation through Department of Children and Family such as emergent placement to alternative living or custodial services.

Nurse Advice Line

FHCP provides a 24/7/365 nurse advice line service to our members. Experienced, bilingual Registered Nurses are available to assist them in making the right choices involving health issues by using evidence-based guidelines. In addition to determining the nature and urgency of your current symptoms and giving directions for the care required, they can also help members better understand diagnoses and prescribed medications, and where and when to go for more help.

Too often, the emergency room is used for non-emergency reasons. Using the Nurse Advice Line can help members get care they need and reduce unnecessary doctor and ER visits, saving time and money. Members can call 1-866-548- 0727 toll free to speak with a nurse. Within the Nurse Advice Line, there is also an option to access a 24-hour Audio Library, containing over 1,500 health topics in English and Spanish, as well as current community health concerns and announcements.
24-HOUR NURSELINE: 1-866-548-0727

Interpreter Services

FHCP is committed to meeting the communication needs of potential and existing individuals who interact with FHCP employees and providers. Individuals with communication issues will be assisted by all FHCP staff and participating non-hospital provider offices at no charge. You should identify and accommodate the special communication needs of members to ensure interpretation is available for individuals who do not speak English, who are deaf or hard of hearing and/or those who utilize sign language as their primary source of communication. Offices in need of assistance with member communication should contact the FHCP Provider Relations Coordinator by telephone 386-615-5096 or email (FHCPProviderRelations5@fhcp.com). The Coordinator will supply the provider office with information needed to contact the appropriate FHCP interpreter vendor to meet the member's communication need. There is no charge to the provider for any interpreter services arranged through FHCP's Provider Relations Coordinator.

Specific FHCP Policies and Procedures related to this topic:
CS011: Transition of Care

We will provide you with notice of any changes and display needed information via updates to this Guide. Updates can be viewed in the "Provider Education" section of our website at https://www.fhcp.com/for-providers/. The current version of the above applicable FHCP policies and procedures are available upon request by contacting the FHCP Provider Services Department at 386-615-5096 or 1-800-352-9824, Opt 1 + 5096. Requests can also be made via email to FHCPProviderRelations5@fhcp.com.

MEDICAL MANAGEMENT/UTILIZATION MANAGEMENT PROCESS

Medical Management/Utilization Management (MM/UM) is a process that helps decide if certain outpatient care services, inpatient hospital stays, or procedures are medically needed and covered by the plan. We make this decision based on what is right for each member and on the type of care and service.

We look at standards of care taken from:
- Medical policies
- National coverage guidelines/criteria
- Plan health benefits

You should know:
- Employees, consultants, or other providers are not rewarded or offered money or other incentives to deny care or service.
- Employees, consultants, or other providers are not rewarded for supporting decisions that result in the use of fewer services.
- We do not make decisions about hiring, promoting or firing employees, consultants, or other providers based on the idea that they will deny benefits.
- You can speak with someone in the MM/UM department by calling 386-676-7187. Translation services are available to our non-English speaking members when they call the FHCP Member Services number. For those with hearing impairment or speech loss, call TTY: 1-800-955- 8770.

FHCP Utilization Management Criteria

Florida Health Care Plans is licensed to use MCG (formerly Milliman) Care Guidelines® and CMS National and Local Coverage Determinations to guide utilization management decisions. If no appropriate MCG or CMS guideline is available, Blue Cross & Blue Shield (BCBS) medical policy guidelines may be used. This may include but is not limited to decisions involving pre-certification, inpatient review, level of care, discharge planning and retrospective review. The MCG Guidelines® license includes (1) Inpatient and Surgical Care Guidelines, and (2) General Recovery Guidelines, Skilled Nursing Facility and Home Health Care. Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the clinical UM guidelines. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law.

A clinical UM guideline does not constitute plan authorization, nor is it an explanation of benefits. Clinical UM guidelines can be highly technical and complex and are discussed here for informational purposes. These guidelines do not constitute medical advice or medical care. Treating health care providers are solely responsible for diagnosis, treatment and medical advice. These guidelines address the medical necessity of existing, generally accepted services, technologies and drugs.

While the Pharmacy guidelines developed by Florida Health Care Plans are published on the FHCP web site, the licensed standard MCG Guidelines® are proprietary to MCG and not published on our Internet site.

UM decision making is based only on appropriate care and coverage. Florida Health Care Plans does not reward staff for making denials and does not use financial incentives that reward underutilization.

About National and Local Coverage Determinations for FHCP Medicare Members

The Centers for Medicare & Medicaid Services (CMS) have established policies to determine whether a service is reasonable and necessary according to Medicare guidelines. For our Medicare Advantage members (FHCP Medicare), we will apply guidelines established in National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) to determine medical necessity under these products. In the absence of

policy in either of these sources, we may use criteria established in our medical policies or Medical Coverage Guidelines (MCG). These policies are in addition to any benefit limitations/exclusions as outlined in the member's Evidence of Coverage (EOC). Additional guidance may also be found in the Medicare Claims Processing Manual or the Medicare Benefit Policy Manual found on www.cms.gov.

A **National Coverage Determination** (**NCD**) is a nationwide determination of whether Medicare will pay for an item or service. Medicare coverage is limited to items and services that are considered reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category).

In the absence of an NCD, an item or service may be covered at the discretion of Medicare contractors based on a **Local Coverage Determination** (**LCD**). Each Medicare Advantage contractor can use an LCD to establish which services are reasonable and necessary within its jurisdiction and, therefore, covered as a Medicare benefit.

Procedure and diagnosis codes are audited before Medicare Advantage claims are paid to ensure the service or treatment meets all Medicare Coverage Guidelines (MCG) and for compliance with Correct Coding Initiatives (CCI). If upon review, it is determined that the service does not meet Medicare NCD, LCD, MCG, or CCI guidelines, the claim may be denied, and the provider may not bill the member for the service.

Physicians and other providers are responsible for understanding whether specific items and services are covered under Original Medicare and, therefore, also covered by our Medicare Advantage plans. A member's eligibility and benefits may be verified electronically through the FHCP Provider Portal or Availity®[1] at Availity.com. If there is uncertainty regarding whether a service requested by a member is covered under Medicare, the provider or the member may request a pre-service "Organization Determination" from the plan. You may also request a pre-service "Organization Determination" for issues related to referrals.

If the pre-service Organization Determination is **denied** and the provider still renders the service, the claim must be billed using a -GA modifier (indicating a waiver of liability statement, known as an Integrated Denial Notice (IDN) for Medicare Advantage plans, was issued by the provider in advance, as required by plan guidelines).

The -GA modifier may only be billed if both an adverse Organization Determination was received and the member's signature is on file in the provider's record, indicating that the member was advised in advance of the service and clearly understands that it is not covered and that he/she has agreed to be responsible for the cost of the service. If the provider did not obtain the IDN in advance of providing a non-covered service, then the member may not be billed for that service.

We may not pay for the referred services if it is outside of our contractual agreements, and the provider would be responsible for the payment and is not allowed to bill the patient, except for the applicable cost- sharing for that service as set forth in the member's EOC.

Also, under Medicare Advantage, unlike Original Medicare, providers are prohibited from using an Advance Beneficiary Notice (ABN). Instead, the pre-service "Organization Determination" process described above must be followed, and the IDN used in place of an ABN.

For more information regarding edits, policies or Organization Determinations, please refer to:

- The CMS Medicare Coverage Database for information about NCD and LCD guidelines applicable to

services rendered in Florida. These guidelines can be found at www.cms.gov.

- First Coast Service Options - Medicare LCD at http://medicare.fcso.com for information about LCD guidelines.

Complaints, Grievances and Appeals

We are dedicated to providing our members with access to quality healthcare and services. We offer complaint, grievance, and appeal processes designed to provide a prompt resolution to your or our member's request. Reasons for submitting a complaint, grievance, or appeal may include dissatisfaction with or disagreement with:

- Quality of care or service
- Plan or administrative practices
- Coverage, benefit, or payment decisions

When you or the member calls with a complaint we will document your concerns and take appropriate action. If you submit your complaint in writing, this is known as a grievance. We will also contact you verbally and in writing with the status of your complaint.

Appeals

When you or our member disagree with FHCP's denial of a claim, denial of a prior authorization request, or notification that a service you are providing or the member is receiving is going to end, you both have the right to appeal the decision. An appeal is a request for FHCP to take another look at our decision and reconsider.

If your or your patient's request for prior authorization for a service is denied or you receive a denial for payment of a claim, you will receive a written notice of a denial. The denial notice will include the reason for the denial, your right to appeal the decision, and information on how to submit your appeal.

If FHCP has notified you that a service you are currently providing, such as home health care or skilled nursing care, is about to end, you will be informed about the reason for the decision and your right to appeal the decision.

Appeal Response Timeframes (FHCP will notify you of our response within):

- Prior Authorization — 30 days or less
- Claims Denial — 60 days or less
- Expedited Review (end of service or urgent pre-authorization) — 72 hours or less

Appeal Decisions
If we decide an appeal in your favor, FHCP will do the following:

- Pay the claim
- Approve the requested service
- Approve the continuation of the service you are receiving

If we decide our original denial was correct, FHCP will notify you and the member verbally and in writing of the reason(s) for our decision. This notice will also include available rights to take your appeal one step further by requesting an external review by an organization not affiliated with FHCP. The External Review Organization available to you depends solely on your benefit type.

For more information about referrals, prior authorizations, or other Utilization Management processes, contact FHCP Member Services. After hours information is also available through our Call Center.

Referrals and Prior Authorizations

It is important to understand the difference between a Referral and a Prior Authorization, and how and when to obtain each one.

A **Referral is a practitioner's "order" or a member request** that facilitates a recommendation that a member see another practitioner (example: a specialist) for consultation or health care services that the referring practitioner believes is necessary but is not prepared or qualified to provide (example: a PCP thinks the patient needs to see a Cardiologist). This referral/order goes directly to the in-network Cardiologist for an appointment and does not come to FHCP for authorization). A referral may be submitted by any practitioner electronically, by telephone, or in writing by fax or regular mail. A member can request a referral by calling his/her PCP or FHCP Member Services.

Prior authorization is the process of reviewing a request for specific medical services to ensure that the services are both medically necessary and covered by the benefit plan. A request for services in need of prior authorization will be submitted from the physician to FHCP Central Referrals department. Most services at FHCP do not require prior authorization, and those that do require prior authorization are listed in the Summary of Benefits, Evidence of Coverage, on the FHCP website, and also through the FHCP Provider and Member portals (at www.FHCP.com).

Most requests are approved, however, if the requested service is not authorized, the member and provider are notified in writing. The notice will include the specific reasons for denial, member and provider rights to appeal, and information on how to submit an appeal.

Contact Referrals at 386-238-3230 or 1-800-352-9824, Ext. 3230 with questions regarding referrals and prior authorizations. The hours of operation are Monday- Friday, 8 a.m. - 5 p.m.

For FHCP members, referrals may be obtained from the member's Primary Care Physician (PCP) or from a participating specialist and / or ancillary location (i.e. Hospital, Rehab, and Free-Standing Facilities). Some referrals require prior authorization from FHCP to be covered.

Direct Access Providers

There are several specialties that do not require a referral for covered services. These are listed as "Direct Access Providers" in the Provider Directory and include (but are not limited to):

- Podiatrists
- Dermatologists
- Chiropractors
- Gynecologists for women's routine and preventive health services
- Obstetricians for obstetrical care
- Providers of most preventive care who participate in a FHCP network (i.e., annual physical exam, colorectal screening, etc.)
- Providers/physicians rendering Urgent and emergency care
- Optometry - Routine eye exams, diabetic retinal exams and Medicare covered glasses do not require a referral

Prior Authorization Requirements

An authorization is defined as an approval of medical services by a health plan or insurance company, usually prior to services being rendered. Unless related to emergency care, failure to obtain a prior authorization from

FHCP for the procedures listed below will result in the member and/or provider being held financially responsible for the procedure.

The following are examples of non-emergency services that **require FHCP Prior Authorization** of coverage:

- All inpatient services
- All Medications as identified on the FHCP Formulary, or FHCP Policy requiring Prior Authorization
- All non-emergency services rendered by non-participating providers or facilities in or out of FHCP's Service Area
- Braces, Orthotics, Prosthetics
- Breast MRI's (Review instructions in the Provider Referral Guide for the specific network)
- Cardiac Rehabilitation
- Wound Care (Review instructions in the Provider Referral Guide for the specific network)
- Chemotherapy treatment (Non-Medicare members only)
- Clinical Trials
- Genetic Testing
- Hyperbaric Oxygen Therapy
- Investigative or other services outside the realm of accepted mainstream medical care
- Lymphedema Therapy
- Oral Surgeon Referral or Oral Surgery
- PET Scans
- Plastic Surgeon Referral or Plastic Surgery
- Pulmonary Rehabilitation
- Radiation Therapy
- Second or third opinion requests
- Surgeries/Procedures that are inpatient, 23-hour Observation, or Outpatient status
- Tertiary Care – Highly specialized consultative care that has personnel & facilities for advanced medical investigation and treatment
- Transplants -Organ and Bone Marrow
- Varicose Vein evaluations and treatment
- Vestibular Rehabilitation
- Wound Vacs

Note: Members should be referred to a participating provider (set forth in the FHCP Referral Guides) to maximize benefits and to avoid higher out-of-pocket expenses.

Referral Guides

FHCP maintains Referral Guides that are geographically specific to various service areas. You should reference the Guide specific to the geographical area for your practice when referring a FHCP member to another provider. The FHCP Referral Guides include specific detailed information regarding how to refer members within FHCP's networks for care, prior authorization requirements, participating providers and service specific documentation requirements. You can access the Referral Guidelines via the FHCP Provider Portal or the **FOR PROVIDERS + Referrals, Prior Authorizations and Orders** section of FHCP's Website www.fhcp.com.

Referral Guides specific to geographic service areas links are below:

- **Referral Guidelines for Brevard County**
- **Referral Guidelines for Volusia/Flagler Counties**
- **Referral Guidelines for Seminole County**
- **Referral Guidelines for St. Johns/Putnam Counties**

Emergency Care

In the event of an illness or injury, it can be difficult for members to decide where to go for care. If a member experiences, call or presents to your practice with emergency symptoms, you or a staff member should advise them to seek immediate treatment by calling 911 or going to the nearest emergency room. **Prior authorization from FHCP is never required for emergency care.**

Urgent Care / Acute Care

If your patient has acute symptoms, and you cannot treat them in a timely manner, you can refer them to one of our FHCP Extended Hours Care Centers or to an Urgent Care Center in network. We advise members that for all non-emergency services to please call their Doctor/Primary Care Physician first for assistance. NOTE: Member out-of-pocket cost will be less if they go to their PCP or to one of the FHCP Extended Hours Care Centers. FHPC Prior authorization is not required for urgent/acute care.

We encourage members to call their PCP first, but if he or she isn't available, our Extended Hours Care Centers are an affordable and convenient option. Or, members may access care through Doctor on Demand video visits.

Please advise FHCP members to call FHCP Central Scheduling at 386-676-7198 or toll free at 1-855-210-2648 between the hours of 7 a.m. - 7 p.m., Monday through Friday to make a same-day appointment at one of our Extended Hours Care Centers. We have several facilities that offer services on Saturday and Sunday.

Specific FHCP Policies and Procedures related to this topic:

RR017: Affirmative Statement About Incentives
UM002: Utilization Management Program
UM011: Medical Appliances Formulary
RF005: Central Referrals Department Guidelines for Processing Medical & Behavioral Health Referrals that Require Pre-Authorization – Prospective Initial Organization Determinations for Non-Medicare Members
RF008: Central Referrals Department Guidelines for Processing Medical & Behavioral Health Referrals that Require Pre-Authorization – Prospective Initial Organization Determinations for Medicare Members
CM001: Concurrent Review
CM006: Discontinuation of Home Health or SNF Coverage
UM008: Retroactive Authorization Process
MCG010: Development of Clinical Review Criteria & Evaluation of New Technology
MCG013: New Technology and Organizational Determinations
MCG007: Bariatric Surgery Coverage
CS004: Medicare Part C Member Complaints/Grievances
CS005: Non-Medicare Member Complaints/Grievances
CS006: Medicare Part C Organizational Determinations & Appeals
CS011: New Member Transition Process
LD015: FHCP Interpreter Services Policy

We will provide you with notice of any changes and display needed information via updates to this Guide. Updates can be viewed in the "Provider Education" section of our website at https://www.fhcp.com/for-providers/. The current version of the above applicable FHCP policies and procedures are available upon request by contacting the FHCP Provider Services Department at 386-615-5096 or 1-800-352-9824, Opt 1 + 5096. Requests can also be made via email to FHCPProviderRelations5@fhcp.com.

QUALITY IMPROVEMENT AND PATIENT SAFETY

FHCP's ongoing quality improvement efforts help improve the health and satisfaction of our members by ensuring safe, effective, and timely care services. FHCP has a robust quality improvement program and work plan designed to improve member access to appropriate and timely health care and services. FHCP is also accredited by the National Committee for Quality Assurance (NCQA). NCQA measures the clinical quality performance of health plans nationally, using standardized measurement criteria known as the Healthcare Effectiveness Data and Information Set (HEDIS). The criteria are used to assess performance in a variety of areas, including effectiveness of patient care, access and availability of care, patient experience, and management of health conditions. Your cooperation in providing certain data helps ensure that our HEDIS measures accurately reflect the high quality of care that our provider network delivers to our members.

FHCP further ensures the safety and quality of health care provided to our members by:

Providing education to our members

- Members receive information to assist them in making appropriate health care decisions, including member rights and responsibilities, quality and safety resources, prevention outreach and behavioral health materials.

Monitoring adverse events

- Quality of care issues identified during health plan activities are investigated, reviewed, and when necessary, sent to peer review.

Monitoring complaints

- Member complaints are reviewed for possible quality of care, services, and access and availability issues. Aggregate results are reviewed for trends and opportunities for improvement.

Pharmacy management

- FHCP pharmacies ensure that processes are followed to oversee overutilization, polypharmacy issues, and appropriateness of prescribing, narcotic abuse, and medication management.

Promoting Continuity and Coordination of Care

- FHCP's Utilization Management, Case Management, Community Resource and Behavioral Health teams meet regularly to improve continuity and coordination of care between practitioners to avoid miscommunication that can lead to poor outcomes for our members.

Utilizing Evidence-Based Clinical Practice Guidelines

- Because evidenced-based research provides the basis for clinical practice guidelines, all FHCP guidelines are based on the most current scientific evidence.

Assessing New Technologies

- FHCP's Pharmacy and Therapeutics Committee reviews and makes recommendations on the latest trends in medical care and new technologies. Recommendations are based on several factors including medical literature, FDA approval, recommendations by national specialty boards and organizations, patient outcomes, and nationally recognized medical criteria.

Implementing Lean Management Processes

- FHCP care centers utilize Lean Daily Management (LDM) processes to reduce adverse events, improve care experience, promote efficiency, and increase employee satisfaction.

FHCP COMMERCIAL AND MEDICARE FORMULARY INFORMATION

The Florida Health Care Plans formularies are an extensive list of FDA approved brand and generic drugs used to treat the most common medical conditions. We have different formularies for Commercial, Self-Insured, and Medicare plans.

The FHCP Formulary is developed by FHCP's Pharmacy and Therapeutics Committee (P&T). The committee consists of physicians, pharmacists, and nurses who review drugs based on safety, efficacy, tolerability, and cost. The P&T Committee reviews and updates the drug list quarterly. New drugs and newly available generics are added as needed, and drugs that are deemed unsafe by the Food and Drug Administration (FDA) are immediately removed.

The most current FHCP formularies are available online. Any questions or concerns regarding FHCP Formularies should be addressed to FHCP Pharmacy Services at 386-615-5008.

Commercial members:
https://www.fhcp.com/for-providers/. Then click on the "+" for Medication Formularies and select the formulary appropriate for your patient's FHCP product line.

Medicare members:
https://www.fhcpmedicare.com/medicare/resources-and-tools/prescription-drug-information-documents/

Formulary Requirements for Coverage

An FHCP member's prescription drug benefit provides coverage for drugs listed in each of the therapeutic classes of the FHCP Formulary. The FHCP Formulary represents the major therapeutic classes and should serve as a quick reference to you or your patient for those covered drugs within the classes listed.

Generic medications offer the lowest cost options to our members and are available at a Tier 1 or Tier 2 copay. We encourage you to check the formulary to see if a generic is available to treat your patient's condition.

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- (DL) Dispensing Limit: These drugs cannot be dispensed for more than a 31-day supply.
- (PA) Prior Authorization: FHCP requires you or your patient to get prior authorization for certain drugs. This means that you will need to get approval from FHCP before the member can fill their prescription. If you do not get approval, FHCP will not cover the drug. **Prior Authorization drugs must be obtained from FHCP pharmacies in order to be covered.**
- (PREV) Preventive Medications*: The Affordable Care Act requires coverage of certain preventive medications without any patient cost-sharing. The preventive medications listed on formulary are available to "ACA compliant" and "Non-Grandfathered" plans only. **Preventive medications must be obtained from FHCP pharmacies.**
- (QL) Quantity Limits: For certain drugs, FHCP limits the amount of the drug that FHCP will cover. For example, FHCP provides 4 ounces per prescription for cough syrups. This may be in addition to a standard one-month or three-month supply.
- (ST) Step Therapy: In some cases, FHCP requires you to first try certain drugs to treat the patient's medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, FHCP may not cover Drug B unless you try Drug A first. If Drug A does not work for the patient, FHCP will then cover Drug B. **Step therapy drugs must be obtained from FHCP pharmacies.**
- (SP) Specialty Pharmacy Only: Certain drugs can only be filled via specialty pharmacies. In most cases,

the name of the specialty pharmacy that must be used will be listed in the Requirements/Limits column on the formulary. The contact information for those pharmacies is also listed in the Formulary.

Any drug not listed in the FHCP Formulary is considered a non-covered drug and is subject to a higher member out-of-pocket cost.

You should contact us to ask us for an initial coverage decision for a formulary, tier or utilization restriction exception. When you request a formulary, tier or utilization restriction exception, you must submit a statement supporting your request. Generally, we must make a decision within 14 days of receiving your supporting statement. You can request an expedited (fast) exception if you believe that the member's life or health could be seriously jeopardized by waiting up to 14 days for a decision. If your request to expedite is granted, we must give you a decision no later than 24 to 72 hours after receiving your supporting statement.

Drug Transition for Non-Medicare Members

All new members on our plan, who may be taking drugs that are not on the FHCP Formulary, or have additional requirements or limits on coverage, may receive a 31-day transition supply (unless the prescription is written for fewer days) from a preferred FHCP Pharmacy during the first 90 days of enrollment. The drug will be covered at either a tier 2 (non-preferred generic) or tier 4 (non-preferred brand) copay or coinsurance. After the initial 31-day transition supply, FHCP will not pay for these drugs even if a member has been on the plan less than 90 days.

Specialty medications are excluded from transition and will require review and Prior Authorization through the Referral Department prior to coverage.

Members are advised to speak to the pharmacist and prescriber to determine the right course of action.

Medicare Formulary Transition Policy

Overview

We want to make the transition to FHCP for new Medicare Part D members as seamless as possible. During the first 90 days of coverage, FHCP will provide a 31-day transition supply of eligible Part D drugs (unless the prescription is written for fewer days) to members who:

- Are taking a Part D eligible medication that is not on the formulary; or
- Are taking a medication that is subject to certain restrictions such as prior authorization, quantity limits or step therapy.
- Are taking a medication that has an approved quantity limit that is lower than the beneficiary's current dose.

Members who have a Low-Income Subsidy (LIS) will not be charged a higher cost sharing for transition supplies than the statutory maximum copay amounts set by Centers for Medicare and Medicaid Services (CMS). Non-LIS members will be charged the same cost share amount that is charged for drugs approved through formulary exception (non-preferred tier 2 or tier 4).

Current members affected by a negative formulary change from one year to the next, will be provided a 31-day transition supply of the non-formulary drug during the first 90 days of the new plan year. This 90-day period will extend across plan years for members who enroll on November 1st or December 1st.

When the pharmacy submits a claim for a transition supply, a letter is sent to the member and the provider within three business days of the claim being submitted. The letter explains the

reason for the transition supply and what action can be taken to request a coverage determination.

Who is eligible?
Newly eligible Medicare Part D participants or those enrolling from another plan during their first 90 days of membership.

What are the details of the long-term care facility transition policy?
All members residing in a long-term facility (LTC) who are new to FHCP will be eligible to continue their medications through a network LTC pharmacy. LTC members who receive their medications through network LTC pharmacies will receive up to a 31-day fill. Members who experience a transition in care from an LTC to home will be eligible for a 31-day transition supply of medication.

What If there are no Medically Appropriate Formulary medications for my Non-Formulary medication?
You or your patient can contact FHCP's Member Services Department at the number listed below and have a right to request an exception to the Florida Health Care Plan formulary. You or your patient
will be asked to submit clinical documentation to support the necessity of the medication.

How Can I or my patient get help finding a lower cost Formulary Medication?
You or your patient may request to speak with one of our clinical pharmacists Monday through Friday 8:30am-5:30pm by contacting our Member Services Department at 386-615-4022 or 1-877-615-4022, 8:00 am to 8:00 pm, 7 days a week. The Hearing Impaired may call TRS Relay 711.

Specific FHCP Policies and Procedures related to this topic:
MCG004: Medications Requiring Prior Authorization
MCG005: General Part D Medication Transition Process
MCG013: New Technologies and Organizational Determinations
MPG012: Previous Medical Records
MCG010: Clinical Review Criteria and New Technology

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PREVENTIVE CARE INITIATIVES

Health and Wellness

FHCP has adopted a population health focus aimed at helping our members get healthy, stay healthy, and manage existing chronic diseases. As part of our Population Health Management (PHM) strategy, we evaluate the needs of our entire membership to connect you with PHM programs and services tailored to your needs.

Our PHM programs include:

- Annual Flu Shots
- Breast Cancer Screening
- Diabetic Retinal Exams
- Asthma Medication Management
- Readmission Prevention Initiative
- Health Service Navigation

In addition to the above programs, other PHM services may be available, such as:

- Community Resource Coordinators
- In-home visits with a mid-level practitioner after a hospitalization
- Mobile lab and radiology services
- Self-management tools in the FHCP Member Portal

Please visit www.FHCP.com/health-wellness or call 386-676-7100, Ext. 7637 for detailed information about FHCP's Population Health Management programs, including how to help a member enroll or opt-out. FHCP also offers members a variety of health and wellness programs and services at little or no cost. Members are not limited by the number of programs they may participate in. For more information, go to www.FHCP.com or call the number listed under each program, Monday through Friday from 8 a.m. to 5 p.m. Hearing impaired call TRS Relay 711.

Acute Low Back and Neck Pain

This physical therapy program helps members manage acute or chronic low back or neck pain. Open to all members age 17 and up, members can contact Ability Health Services (all locations) or Palm Coast Sports Medicine directly. Co-pay/co- insurance and policy limits apply. For more information or to obtain a list of facilities, have the member call FHCP Member Services.

Case Management - Coordination of Care

This is a free program offered to members who may benefit from assistance with coordinating their medical, psychosocial, and financial needs. Working with members and their physicians, Case Managers can provide the education and resources needed for members to better understand and comply with their plans of care. Other programs are available to meet member health care needs include patient monitoring, in-home medical management and community resources coordination. A Case Manager will help you determine which programs are right for your patient. The FHCP Case Management Department can be reached at 386- 238-3284 or toll free at 1-855-205-7293.

Hypertension

FHCP offers a two-hour hypertension self-management class taught by Registered Dietitians. This free class focuses on the DASH (Dietary Approaches to Stop Hypertension) diet and low sodium education. For more information or to have your patient register, call the FHCP Diabetes/Health Education Department at 386-226-4518 or toll free at 1-877-229-4518.

Diabetes

This free program provides educational materials to assist members with management of their diabetes. For more information, contact the FHCP Diabetes/ Health Education Department at 386-226-4518 or 1-877-229-4518.

Diabetes Education Program
Recognized by the American Diabetes Association (ADA), and conducted by FHCP registered nurses and registered dietitians/Certified Diabetes Educators (CDEs), this free 10-hour diabetes education program covers: diabetes overview, complications, signs and symptoms of high and low blood sugar, lifestyle modifications, medications, nutrition, monitoring guidelines (HgbA1C, blood glucose meters, blood pressure, weight), and foot, skin, and dental care. In addition, CDEs are also available for individual appointments. For more information, contact the FHCP Diabetes/Health Education Department at 386-226-4518 or 1-877-229-4518.

Nutrition Game Plan for Diabetes
This two-hour session is recommended for members who have completed the 10- hour Diabetes Education Program. The class reinforces disease specific nutrition education and answers questions regarding diabetes. For more information, call the FHCP Diabetes/Health Education Department at 386-226-4518 or 1-877-229-4518.

Diabetes Prevention Program
This free, two-hour class is designed to help members identify risk factors for developing diabetes. It includes information about nutrition, exercise, and behavioral strategies for prevention. A more intense diabetes prevention program also is available. For more information, call the FHCP Diabetes/Health Education Department at 386-226-4518 or 1-877-229-4518.

Healthy Heart Nutrition Program
This free class helps members identify risk factors for heart disease and offers tips for improving lifestyle to reduce those risks. For more information, call the FHCP Diabetes/Health Education Department at 386-226-4518 or 1-877-229-4518.

Osteoporosis
This program is for members who are at risk for or have been diagnosed with Osteoporosis or Osteopenia. Therapists at Ability Health Services will perform an evaluation and physical assessment to determine strength, endurance and activity level. Members can call Ability directly; no referral is needed. Co-pay/co-insurance and policy limits may apply. For more information or to obtain a list of facilities, call FHCP Member Services.

Preferred Fitness / Gym Access
This free fitness program is provided to all FHCP Medicare members and certain employer groups. Eligible members have unlimited access to a variety of quality health and fitness facilities in Volusia, Flagler, Brevard, St. Johns and Seminole counties. For a current list of facilities, visit our website or have your patient call FHCP Member Services.

Commercial members: www.FHCP.com Medicare members: www.FHCPMedicare.com

Weight Management
“Eat Right, Move Right” is a free six-week course that promotes a lifestyle change approach to weight loss for members with a Body Mass Index (BMI) over 27. Class topics include how to increase activity, improve eating habits, and change behaviors for permanent weight loss. Members will learn to set realistic goals, make behavior changes, use the USDA plate method, manage dining out experiences, and change food shopping habits. For more information, call the FHCP Diabetes/Health Education Department at 386-226-4518 or 1-877-229- 4518.

Smoking Cessation
Tobacco Free Florida (TFF) is a free, statewide smoking cessation and prevention campaign. The program is managed by the Florida Department of Health through the Bureau of Tobacco Prevention. Smokers and smokeless tobacco users interested in assistance with quitting are encouraged to call the Florida Quitline at

1-877-U-CAN-NOW (877-822-6669) to speak with a Quit Coach®. To access TFF's additional quit smoking resources, visit the Tobacco Free Florida website at www.tobaccofreeflorida.com.

Medicare Advantage- FHCP Medicare Preventive Benefits

Medicare Advantage plans cover many preventive services for members. The goal of preventive care is to prevent disease and its consequences. Preventive care includes programs aimed at warding off illnesses (e.g., immunizations), early detection of diseases and inhibiting further deterioration of the body.

The following preventive care services are covered:

- Annual flu vaccine
- Colorectal cancer screening
- Cologuard
- Annual fecal occult blood Barium enema (can be substituted for sigmoidoscopy or colonoscopy)
- Flexible sigmoidoscopy
- Screening colonoscopy
- Hepatitis B vaccine for intermediate or high-risk beneficiaries
- Periodic health assessments by the member's primary physician
- Pneumococcal vaccine
- Annual pap smear and clinical breast and pelvic examination
- Mammograms, screening and diagnostic
- Bone mass measurements
- Prostate cancer screening exam
- Diabetes monitoring, training and supplies (includes annual diabetic retinal eye exam, glucose monitors, test strips, lancets, and self-management training for members with diabetes)
- Abdominal aortic aneurysm screening
- Screening and behavioral counseling interventions during primary care to reduce alcohol misuse
- Screening for depression in adults
- Intensive behavioral therapy for cardiovascular disease
- Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling
- Annual Wellness Visits
- HIV Screening
- Intensive behavioral therapy for obesity
- Lung cancer screening
- Medical nutrition therapy
- Smoking and tobacco use cessation

FHCP Medicare, Florida Blue and other Blue Cross and/or Blue Shield Plans, may supply providers available information concerning an individual's status, eligibility for benefits, and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits.

Specific FHCP Policies and Procedures related to this topic:

MPG012: Preventive Medicine Recommendations

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request by contacting the FHCP Provider Services Department at 386-615-5096 or 1-800-352-9824, Opt 1 + 5096. Requests can also be made via email to FHCPProviderRelations5@fhcp.com.

PROVIDER BILLING GUIDELINES

This section of the *Manual for Physicians and Providers* explains certain aspects of the claim process. Unless otherwise noted, the below payment policies apply to all FHCP product lines. All provider claims should be submitted electronically whenever possible.

FHCP Provider Portal and Availity Claims Processing Information

Participating Providers:
All providers participating in FHCP's networks should use FHCP's Provider Portal to view FHCP member eligibility, benefits, authorization and claim status information. Member benefit information includes real time accumulator totals for member deductible and maximum out of pocket in comparison with their benefit plan limits. Claim status information includes the stage of the claim in the adjudication process, the amount approved, the amount paid, the member's cost and date paid.

In addition to these functions, participating providers can view member service history, PCP panel counts, member lab results, and other helpful information and documents related to supporting provider interaction with our members. For example, you can use the Portal to securely upload and send FHCP required claims or authorization documentation, etc. as well as enter and send your claims and authorization requests to FHCP electronically.

Click on the FHCP Provider Portal link to register to use this valuable tool. **If you have any questions about obtaining access, please call (386) 615-4090 opt. 4, or email helpdesk@fhcp.com.**

Non-participating Providers:
Availity is used by FHCP to supply non-participating providers with eligibility, benefit, claims and authorization status information. FHCP is included as a health plan choice on Availity's website.

If you have any questions about access, please contact Availity Client Support at 800 / AVAILITY (282-4548) or support@availity.com.

Site of Service

Based on the CMS methodology, FHCP will reimburse specific CPT/HCPCS codes based on the site of service where the service is performed. This differential recognizes that physician practice costs are generally lower when services are provided in a facility location. This approach has been used by Medicare for several years and is consistent with standard practices in the health care industry. To determine which services and locations are reimbursed at the facility rate, FHCP uses the same criteria that are applied by Medicare. To identify the services for which a Site of Service differential applies, you can consult the CMS website .

Substitute Physicians

A substitute physician, sometimes called a locum tenens physician, is a physician who is hired to temporarily replace another physician ("usual" physician). The usual physician may be absent for reasons such as illness, pregnancy, vacation or continuing medical education. This absence should not exceed 60-days unless the usual physician has been called to active duty in the Armed Forces. The usual physician bills and receives payment for the substitute (locum tenens) physician's services as though the usual physician performed the services. The usual physician is responsible for reimbursing the substitute (locum tenens) physician for services rendered and ensures that the substitute (locum tenens) physician shall not bill or seek payment from the member. The usual physician identifies the reported services as locum tenens physician services by

entering code modifier Q6 (service furnished by a locum tenens physician) after the procedure code on the CMS-1500 claim form.

Advanced Non-Physician Practitioners (Physician Extenders)

Advanced Non-Physician Practitioner (Physician Extender) services should be billed with the extender's NPI number in block 24J on the CMS-1500 as the rendering provider.

FHCP requires a separate claim for each rendering provider. A single service rendered by two or more providers for the same member on the same date of service must be billed with the provider who performed the substantive portion of the service in block 24J. Illustrative examples are listed below:

- If the Physician Extender performs the history and physical and the physician evaluates the patient's medical condition, orders tests, and develops a treatment plan, then the service should be billed with the physician as the rendering provider.
- If the Physician Extender performs the history and physical, evaluates the patient's medical condition, orders tests, and develops the treatment plan and the physician enters the examination room to confirm the diagnosis and treatment plan, then the service should be billed with the Physician Extender as the rendering provider.

Physician Extenders

Physician Extenders should not submit claims under the following circumstances:

- Services were not personally performed. The supervision of other staff does not constitute a personally performed professional service.
- A facility, hospital, or birthing center is paid an allowance for the extender's professional services.

Claims submitted are an attestation of services performed. FHCP reserves the right to conduct audits and/or reviews to ensure claims are submitted appropriately.

Covered services rendered by physician extenders not directly contracted with FHCP will be reimbursed at 85 percent of the contracted provider's rate where an RVU exists. Physician Extenders directly contracted with FHCP will be reimbursed at the contracted rate.

Surgical first assist services by a licensed physician extender should be billed by the employing physician, group, employer or clinic with the addition of modifier AS and the physician extender NPI number entered in block 24J as the rendering provider. FHCP will reimburse these services at 16 percent of the allowed amount when the service is covered, and the surgery warrants a surgical assistant.

Electronic Claims

Electronic Claim Submissions allow providers to safely submit and track HIPAA-compliant electronic claims to us without manual intervention. FHCP uses Availity and Relay Health as our clearinghouses for the receipt of Professional (837P) and Institutional (837I) electronic claim files.

FHCP's payer ID is 59322.

For those providers who are not yet sending their claims to FHCP electronically, we request that you begin doing so in HIPAA compliant format. FHCP is in compliance with established requirements for submitting claims in version 5010 of the HIPAA transaction set standards.

Please note FHCP is a health plan choice on Availity's website for EDI files and claims may also be manually entered into the Availity system should your practice management software be unable to generate electronic claims.

Electronic claims must be sent through a billing service or clearinghouse and then route to us. Our EDI clearinghouse vendor edits transactions according to the HIPAA-AS requirements. Several payer specific edits are also performed before routing transactions to FHCP.

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

Prompt Claims Processing/Timely Filing Limits

Providers must file claims within the time set forth in their FHCP participating provider Agreement(s) unless applicable law requires a greater time period for filing of claims. If applicable to a particular benefit agreement, current Florida law and other legal requirements provide that claims must be filed within 180 days after the date of service and receipt by the provider of the name and address of a patient's health insurer. Claims for Medicare member services must be filed in accordance with Medicare billing requirements.

A Provider should submit claims indicating their usual fees for services rendered. FHCP will make appropriate adjustments based on the contractual agreement.

FHCP complies with applicable legislation regarding timeliness of filing and processing claims.

Claim 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 deductibles and coinsurance, 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 access current CPT, HCPCS, and ICD-10-CM code information.

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. Groups often have changes in their health insurance benefit plans. Make re-verifying coverage through the FHCP Provider Portal or Availity a routine in your office.
- Submit the FHCP member ID number. Submit the member ID number not the member's Social Security number. Remember to correct your billing system when there are changes. The 835 electronic remittance

advices will indicate when a member's identification (ID) number is processed with a different identifier than was submitted.

- Complete all claim entry fields. To receive proper reimbursement, the claim information must be completed in its entirety. Incomplete or inaccurate information will result in a claim denial.
- Medicare providers may not balance bill qualified Medicare beneficiaries for Medicare cost share amounts.
- Enter the date of onset, if applicable. All injury related ICD diagnosis codes 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.
- 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.
- Billing provider address is the location where services were rendered and MUST be a street address. For electronic submissions, if the payment address is different than the billing address, submit in the "Pay To" including any P.O. Box.
- Avoid sending duplicate claims. For claims status, use the FHCP Provider Portal or contact FHCP. If filing electronically, be sure to also check your FHCP file acknowledgement and EBR for claim level failures. Allow 15-days for electronic claims and 30-days for paper claims before resubmitting.
- Corrected claims. If you do not submit your corrected claims electronically, then indicate "Additional Services" on claims when billing for additions to the original claim. This will clearly distinguish your claim as being filed in addition to the original, but not replacing the original claim (i.e., a corrected claim). The additional services must be submitted on a paper claim form.
- Taxonomy Code. Claims should contain the proper provider taxonomy code, especially for MA members.
- NPI and Sub-part Identifiers. Claims should also contain the proper NPI for sub-units of a hospital, if applicable, especially for MA members or if the sub-unit is a participating with FHCP. If an NPI was not obtained for sub-units of the hospital, ensure the proper taxonomy code is used when billing FHCP.

Note: To order CMS-1500 (formerly HCFA-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 www.cms.hhs.gov.

Under certain circumstances, FHCP will suspend claims for medical review under an applicable medical or drug policy 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 maybe 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

Risk Adjustment Data Requirements

Due to the Balanced Budget Act of 1997 (BBA), as a Medicare Advantage Plan (MAPDP) FHCP must submit to CMS (in accordance with CMS instructions) all encounter data for FHCP Medicare and Accountable Care Act (ACA) enrollees for service dates 10/01/2000 and after. This data includes all physician inpatient, outpatient and clinic services. FHCP will be forwarding to CMS encounter/claims data exactly as submitted to FHCP by each physician provider.

As a result, each provider will ultimately be responsible for the accuracy of data submitted on their behalf. It is imperative that your medical record documentation support the data reported. Two key elements involved will be the linkage between the diagnosis code and the procedure (CPT) code and coding the diagnosis with the most specificity available.

Incorrect data supplied by providers and submitted to CMS by FHCP will be denied by CMS and returned to FHCP for correction. FHCP will in turn be requesting that providers correct their data and resubmit same to FHCP. Claims data reported by FHCP to CMS will ultimately be used to assign “Risk Scores” to each of our Medicare and ACA members. Future FHCP premium dollar levels paid by CMS to FHCP will be tied into these “Risk Scores”.

Therefore, for dates of service 10/01/00 and after, providers must submit claims or encounter data to FHCP in CMS-1500 format. FHCP’s Risk Adjustment Department is available to assist provider offices with any coding issues or concerns. Risk Adjustment can be reached at (386) 615-5040 or toll free at (800) 352-9824, Ext. 5040. Ongoing audits concerning coding accuracy and completeness will be conducted by the Risk Adjustment Department. Your office will be contacted regarding any identified issues.

Medical Records Documentation of Claims

Requesting Medical Records

When additional documentation is required to process a claim, FHCP will fax or mail a written request to you. The request will include a letter 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.

The following are tips for submitting claim documentation when it is requested:

- For records that contain greater than 50 pages, mail the documentation to FHCP Claims Department, P.O. Box 10348, Daytona Beach, FL 32120-0348
- Do not send double-sided copies.
- Please include a copy of the original letter.

Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed.

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

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

Paper corrected claim:

- Submit a copy of the remittance advice with the correction clearly noted.
- If necessary, attach requested documentation (e.g., nurses notes, pathology report), along with the copy of the remittance advice. To ensure documents are readable, do not send colored paper or double-sided copies
- Boldly and clearly mark the claim as “Corrected Claim”. Failure to mark your claim appropriately may result in rejection as a duplicate
- If a modifier 25 or 59 is being appended to a CPT code that was on the original claim, do not submit as a "Corrected Claim". Instead, submit as a coding and payment rule appeal and supporting medical documentation (e.g., operative report, physician orders, history and physical).

Electronic corrected claim:

Providers with EDI or batch processing can electronically submit corrected claims to us electronically. If you file these claims with the appropriate bill or frequency type codes listed below, then they can be included in your normal electronic submission process (e.g., HIS, PMS). Contact your vendor if you need assistance identifying the loop and segment for the type codes.

For institutional claims, use the three-digit Bill Type (XX7 or XX8) ending in the appropriate number. For professional claims, use the appropriate number (7 or 8) for the Frequency Type.

7 Replacement of Prior Claim: If you have omitted charges or changed claim information (diagnosis codes, dates of service, member information, etc.), resubmit the entire claim, including all previous information and any corrected or additional information.

8 Void/Cancel of Prior Claim: If you have submitted a claim to FHCP in error, resubmit the entire claim.

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)

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

Drug Units

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

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

Diagnosis

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

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 Blue's website.

Provider Electronic Payment Options

Florida Health Care Plans has partnered with VPay to offer an electronic claim payment option for providers using the VPay process. VPay allows your office to receive payments electronically via the MasterCard network. This service will provide a faster and more efficient way for you to receive payment.

Providers accepting VPay will enjoy the following benefits:

- Quick payments. VPay is delivered primarily via fax so you are receiving payments much quicker than checks.
- Easy reconciliation. The VPayment and EOB are delivered together in a single document. Enter the card number in your terminal and post the EOB to your billing system and you are done!
- No bank deposits. Your funds will be delivered electronically to your merchant account.
- VPay eliminates the risk of fraud and guarantees the delivery of funds to your account, regardless of any fraudulent attempt to process a VCard. No more stolen, lost or whitewashed checks.
- VPay's Call Center is staffed with knowledgeable, well trained professionals that can assist with any questions you have about your VPayment.

You do not have to enroll to use VPay. When you receive your VCard, just follow the directions provided on your remittance.

The VPay process also includes an ACH/835 option. You can call the VPay Call Center at (877) 714-3222 to enroll for this service.

We are excited to bring you this safe and efficient electronic method of claims payment. Please keep in mind that you can also check eligibility by registering with Availity at (800) AVAILITY (484-4548). You do not have to file your claims electronically in order to use this valuable service. This service is readily available to you. No more telephone calls!

If you have any questions about this new service, please feel free to contact Claims at Florida Health Care Plans.

Provider Appeals of Denied Claims:

Information for participating providers
Participating providers may find the reconsideration processes in the FHCP Provider Handbook. The Handbook is available above under the Provider Education section.

Reconsideration requests from participating providers should be submitted electronically via FHCP's Provider Portal. Supporting documentation can be uploaded securely through the FHCP Provider Portal.

You may also submit your appeal by mail to:
FHCP Claims Department
P.O. Box 10348
Daytona Beach, FL 32120-0348

Information for non-participating providers
Medicare Advantage plans: appeals for nonparticipating providers. In order to request an appeal of a denied claim, you need to submit your request in writing within 60 calendar days from the date of the denial.

Please include with your request:

- A copy of the original claim
- The remittance notification showing the denial
- Any clinical records and other documentation that support your case for reimbursement
- You will need to include a signed Waiver of Liability Statement form, found on the FHCP website under the For Providers Page, holding the enrollee harmless, regardless of the outcome of the appeal.
- Appeals related to coding edits, clean claim requirements, or payment disputes where there is no member liability do not require a signed Waiver of Liability for FHCP to re-open your claim.

Once you have completed the request, please mail it to:

FHCP Claims Department
P.O. Box 10348
Daytona Beach, FL 32120-0348

Non-Medicare plans: appeals for nonparticipating providers

If you believe the determination of a claim is incorrect, you may file an appeal on behalf of the FHCP member. The appeal will be reviewed by parties not involved in the initial determination. In order to request an appeal, you need to submit your request in writing within the time limits set forth in the Certificate of Coverage if filing on behalf of the covered person.

Please send the appeal to the following address:

FHCP Claims Department
P.O. Box 10348
Daytona Beach, FL 32120-0348

Please include with your request:

- A copy of the original claim
- The remittance notification showing the denial or adjustment
- Any clinical records and other documentation that support your case for reimbursement
- An Appointment of Representative (AOR) Form or other legal documentation authorizing you to act on the covered person's behalf (if you are filing an appeal on behalf of the FHCP member)

EDI Guidelines
Companion Guides - ANSI X12N 5010

- ANSI X12N Implementation Guides for 5010A1 can be obtained from **Washington Publishing Company**.
- Companion Guides:
- **ANSI 270/271** - Health Care Eligibility Benefit Inquiry and Response (PDF)
- **ANSI 276/277** - Health Care Claims Status Request and Response (PDF)
- **ANSI 834** - Benefit Enrollment and Maintenance (PDF)
- **ANSI 837** - Professional Health Care Claims (PDF)
- **ANSI 837** - Institutional Health Care Claims (PDF)
- **ANSI 835** -Electronic Remittance Advice (PDF)
- For 835 Electronic Remittance Advice, **Click Here** to request a Trading Partner agreement and Electronic Funds Transfer agreement.

Note: This information is being provided for reference and convenience only and is not intended to grant rights or impose obligations. The information is only intended as a general summary. It is not intended to take the place of laws, regulations, contracts, or other applicable provisions. You are encouraged to review specific laws, regulations, contracts, and other materials as applicable.

Submit a Paper Claim by Mail:

Please instruct members asking about reimbursement for services rendered by non-participating providers to submit their receipts to the following address:

FHCP Claims Department
P.O. Box 10348
Daytona Beach, FL 32120-0348 or

- Claims may also be sent electronically to FHCP via our payer ID number, 59322 or
- Claims may be entered through Availity at **https://apps.availity.com/**
- Questions regarding the submission of claims should be directed to (386) 615-5010

Participating Provider Claims 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 provider.

This information is intended to serve only as a general reference resource regarding our provider audit and recovery process and is not intended to address all reimbursement situations or all processes that may be utilized.

The Payment Integrity department is responsible for identification and recovery of overpayments through audit activities for all providers. The scope of audit focuses primarily on the identification of claims overpayments and subsequent recoveries.

All claim audits are conducted on a claim-by-claim basis. Some audits review many issues concerning the claims, but others are targeted reviews related to specific issues. A typical audit may include not only a review of the claim itself but also a review of the medical records or other supporting documents to substantiate the claim submitted. Audits may be conducted by us, our customers or governmental, accreditation or regulatory agencies. Providers are required to participate in audits conducted by all such parties, including any contracted vendors utilized to conduct the audits.

Depending on specific claim reimbursement terms, audit reviews may consider, but are not limited to:

- Compliance with contractual conditions and terms
- Appropriateness of coding (e.g., national coding standards; CPT, HCPCS, ICD10-CM, others as applicable)
- Unbundling of services/procedural codes (e.g., Hospital Charge Reimbursement Definitions, Correct Coding Initiative and code editing hardware)
- Billing accuracy
- Duplicate payments
- Member benefits, exclusions and coverage periods
- Claims processing guidelines
- Criteria supporting medical appropriateness of care and/or compliance with Florida Blue's Medical Policies (Medical Coverage Guidelines)
- Accuracy of the authorization and prior approval processes, where indicated or required
- Our payment methodologies

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 participation agreement with us.

In House Audits

Certain audits do not require us to be onsite at the provider's location. Such audits are less costly and administratively burdensome for both us and the provider. Providers are required to provide us with any medical records or supporting documentation required to conduct such desk audits. Desk audits include, but are not limited to the following:

Check Run Audits-Based on the weekly check runs, individual claim payments may be audited based on specific payment parameters for each type of service (e.g., all outpatient claims over a specific dollar amount).

Claims Payment Review - Verifies payment accuracy in accordance with the provider’s contract, applicable processing/coding guidelines and the member’s benefits/limitations.

Targeted Audits - Systemic auditing using certain payment codes, specific contract terms, specific contract load issues, or procedures that have been identified as a concern for all or specific contracted providers.

Special Request Reviews - Review of a specific providers as requested by an account or group, our Medical Operations, Marketing, Special Investigations or other areas within the Plan for a specific purpose.

Provider Audit Process

Notification/Confirmation Responsibilities:
Prior to a provider audit, we will provide notification of at least 10 working days prior to the audit start date via email, mail, telephone or fax.
The notification will include, but not limited to, the following:

- Audit type to be performed
- If applicable, the list of claims with the member name, patient account number and dates of service
- A request for medical documents or components to support billing

For Onsite audits we may request a formal entrance conference with applicable provider designee and our audit staff. The formal entrance conference will take place on the first day of the onsite audit.

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 Responsibilities:

We require formal acknowledgement of the notification of an audit. Acknowledgement should include:

- Contact name and telephone number for 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.

Our 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.

Provider Responsibilities 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 Our Responsibilities:

- 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.

Provider Responsibilities:

- 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.

Escalation Process

Issues and concerns related to findings resulting from an audit should follow a normal course of resolution, which is resolved through:

- Prior to the issuance of the final audit findings, the assigned Florida Blue auditor will review any issues and will refer the matter to the responsible Florida Blue audit manager, if necessary.
- After the issuance of the final audit finding, if provider followed the required process to dispute or contest the audit findings, as outlined above, the matter will be referred to the appropriate resource:
- Contractor/Negotiator
- Medical Director
- Legal Affairs Division

If provider has followed the required process to dispute or contest the audit findings and internal resources are unable to resolve the matter, then either party may proceed to formal dispute resolution in accordance with provider's participating provider agreement.

Exit Process

Our Responsibilities:

An exit conference will be conducted with provider designee including an overview of audit findings. Exit conferences may be conducted via telephone if in person conference is not required.

- Discussion of overpayment recovery process: Upon completion of the audit, repayment will be requested from the provider, to be mailed to the Florida Blue 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.

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 the Healthcare Provider Audit department 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 FHCP. The directions indicated in the audit letter need to be followed to ensure appropriate adjustments and credits are made to the audited claim.

Medicare Advantage Onsite Compliance Audits

To comply with CMS guidelines, selected claims from Medicare Advantage providers are audited on an annual basis. The provider is responsible for ensuring the "original" records are authenticated by one of three forms– handwritten signature, signature stamp, or electronic signature. Transcribed records must have one of the above forms of authentication.

A formal entrance conference will provide the scope and purpose of the audit, arrangements for photocopying and/or scanning of medical documentation, as well as to establish the exit conference criteria.

In cases where discrepancies are noted from the audit, adjustments will be made to the diagnoses based on the medical record documentation.

We will provide information and education to provider staff and possible follow-up audits may be scheduled to ensure encounter data submission accuracy.

Specialized Audits

Specialized audits maybe performed on but not limited to the following:

- Claims payment based on charges
- Catastrophic/Trauma claim audits/claims payment based on charges –
- Itemized bills for inpatient claims, meeting specific provider contractual limitations/conditions and Hospital Charge Profile/Charge Reimbursement definitions in conjunction with our billing guidelines.

Encounter/Claim Data Audits

Medicare Advantage providers will be randomly selected for provider audits to verify compliance with encounter/claim data submission. Providers will be notified 15 working days prior to the onsite audit. The focus of the audits will be:

- To determine based on the audit findings that the encounter/claim data audited is complete, truthful, and accurate.
- To compare reported encounter/claim data to a sample of medical records to verify the accuracy and timeliness of the reported information. The audit unit will provide the provider with written information concerning compliance and/or audit findings.

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, 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 obtain compliance.
- Provider compliance will be re-assessed after 30-days. If it is determined that a provider is complying with encounter/claim data submission, 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.

Specific FHCP Policies and Procedures related to this topic:

SE1128: MLN Matters "Prohibition from Billing dually Eligible Individuals Enrolled in the Qualified Beneficiary (QMB) Program"
PC033: Member Financial Responsibility Estimates

PC034: Participating Provider Payment Rate Disputes
PC028 Non-Participating Provider Payment Rate Disputes Regarding Medicare Beneficiary Claims
PC007: Medicare Subscriber Claims Review and Processing
PC017: Non-Medicare Subscriber Claims Review and Processing
PC008: Initial Determination and Reconsideration of Coverage of Medicare Beneficiary Claims
PC026: Initial Determination and Reconsideration of Coverage of Non-Medicare Beneficiary Claims
PC031: Coordination of Benefits

We will provide you with notice of any changes and display needed information via updates to this Guide. Updates can be viewed in the "Provider Education" section of our website at https://www.fhcp.com/for-providers/. The current version of the above applicable FHCP policies and procedures are available upon request by contacting the FHCP Provider Services Department at 386-615-5096 or 1-800-352-9824, Opt 1 + 5096. Requests can also be made via email to FHCPProviderRelations5@fhcp.com.

FHCP HOLIDAY SCHEDULE

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

FLORIDA HEALTH CARE PLANS

2022 Holiday Schedule

This Flyer contains a list of the 2022 holiday schedule and the dates on which they will be observed by Florida Health Care Plans.

Holidays:	Date Observed:
New Year's Day	January 1, 2022
Memorial Day	May 30, 2022
Independence Day	July 4, 2022
Labor Day	September 5, 2022
Thanksgiving Observance	November 24 & 25, 2022
Christmas Observance	December 24 & 26, 2022