Simply healthcare

Provider Manual

Florida Statewide Medicaid Managed Care Long-Term Care Program

Provider Services: 877-440-3738
https://provider.simplyhealthcareplans.com

Material in this manual is subject to change. Updates will be communicated through provider alerts and posted online. Please visit provider.simplyhealthcareplans.com **and** providernews.simplyhealthcareplans.com **for the most up-to-date information.**

How to apply for participation
If you're interested in applying for participation with Simply, please visit simplyhealthcareplans.com, or call Provider Services at **877-440-3738**.

Table of Contents

1 INTRODUCTION

Welcome to the Florida Statewide Medicaid Managed Care Comprehensive Long-Term Care Plus Plan (SMMC-LTC+) provider network family. We are pleased you joined our network, which represents some of the finest providers in the country.

We bring the best expertise available nationally to operate local community-based healthcare plans with experienced local staff to complement our operations. We are committed to helping you provide quality care and services to our members.

We believe providers are the most critical elements in the success of our health plans. We can only be effective in caring for members by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, quality provider network.

Updates and Changes

The most updated version of this provider manual is available online at provider.simplyhealthcareplans.com. To request a printed copy of this manual, call Provider Services at **877-440-3738**, and we'll be happy to send you a copy at no cost to you.

The provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the agreement between you or your facility and Simply, the agreement governs.

If there is a material change to the provider manual, we will make all reasonable efforts to notify you in advance of such a change through web-posted newsletters, email and fax communications and other mailings. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

2 OVERVIEW

Who Is Simply?

As a leader in managed healthcare services for the public sector, we provide health care coverage exclusively to low-income families and people with disabilities. We participate in the Medicare Advantage, Florida Healthy Kids, Statewide Medicaid Managed Care (SMMC) Long-Term Care and SMMC Managed Medical Assistance programs.

Mission

The Simply mission is to provide real solutions for members who need a little help by making the healthcare system work better while keeping it more affordable for taxpayers. The SMMC-LTC program is designed for older and adult disabled members who need help to remain at home or live in a facility. The program focuses on long-term care needs and provides help for individuals who need assistance in their daily living activities such as bathing, dressing, and housekeeping.

Strategy

Our strategy is to:

- Encourage stable, long-term relationships between providers and members.
- Commit to community-based enterprises and community outreach.
- Facilitate integration of physical, behavioral, and long-term care.
- Provide a full continuum of resources and promote continuity of care for our members.
- Foster quality improvement mechanisms that actively involve providers in re-engineering healthcare delivery.
- Encourage a customer service orientation.

Summary

The Florida legislature created a program called Statewide Medicaid Managed Care (SMMC). As a result, the Agency for Healthcare Administration (AHCA) has changed how some individuals receive healthcare from the Florida Medicaid program.

Two components make up the SMMC program:

- The Florida Managed Medical Assistance (MMA) program
- The Florida Long-Term Care (LTC) Managed Care program

The goals of the MMA program are to provide:

- Coordinated healthcare across different healthcare settings.
- A choice of the best managed care plans to meet recipients' needs.
- The ability for healthcare plans to offer different, or more, services.
- The opportunity for recipients to become more involved in their healthcare.

The goals of the LTC program are to:

- Provide coordinated LTC services to members across different residential living settings.
- Enable members to remain in their homes through the provision of home-based services or in alternative placement, such as assisted living facilities.

The MMA program was implemented in all Florida regions as of August 1, 2014. These changes are not due to national healthcare reform or the Affordable Care Act. Medicaid recipients who qualify and are enrolled in the MMA program will receive all healthcare services other than long-term care through a managed care plan.

3 QUICK REFERENCE INFORMATION

Please call us for program information, claims information, inquiries, and recommendations you have about improving our processes and managed care program.

Simply Long-Term Care Numbers:

- Provider Services: **877-440-3738**
    - Claims inquiry line
    - Case management services
    - Provider Relations

Electronic Data Interchange — Availity Client Services:

- Available Monday to Friday, 8 a.m. to 8 p.m. ET at **800-AVAILITY** (**800-282-4548**) excluding holidays.
- Email questions to support@Availity.com.

Our provider website includes forms and general information about claims payment, member eligibility, and credentialing and recredentialing. Visit our website at provider.simplyhealthcareplans.com. Additionally, visit providernews.simplyhealthcareplans.com to stay current on all news and announcements related to your practice and patients.

Note: We do not cover or arrange for acute care services that are covered by Medicare or Medicaid, such as physician office visits or hospital services; however, we do provide coverage for services in addition to Medicare covered services, sometimes called wraparound services, such as Medicare, coinsurance, and deductibles. Simply case management is responsible for the integration and coordination of Medicare and Medicaid covered services. Medicare and/or Medicaid should be billed for Medicare covered services and/or Medicaid acute care covered services, while Simply should be billed for wraparound and long-term care services.

Ongoing Provider Communications

To ensure you are up to date with information required to work effectively with us and our members, we provide frequent communications in the form of emails, faxes, provider manual updates, newsletters, available training, and information posted to the website. Sign up here to start receiving provider communications emails from us.

Visit our Training Academy for resources and training materials online. Here is where you can access Provider Pathways, a 24/7 educational resource that offers a foundation for doing business with Simply.

Visit the Availity Provider Learning Hub to take Live and On-Demand training on the Availity capabilities which include:

- Eligibility & Benefits
- Claim Status
- Appeals/Dispute
- Authorization/Referrals
- Medical Attachments
- Provider Data Management

- Claim Submission

4 PROVIDER RESPONSIBILITIES

The provider shall:

- Practice in their profession ethically and legally, provide all services in a culturally competent manner, accommodate those with disabilities, and not discriminate against anyone based on their health status.
- Participate and cooperate with Simply in quality management, utilization review, continuing education and other similar programs established by Simply.
- Participate in and cooperate with our grievance procedures when we notify the provider of any member complaints or grievances.
- Not balance bill a member.
- Comply with all applicable federal and state laws regarding the confidentiality of member records.
- Support and cooperate with the Simply Quality Management program to provide quality care in a responsible and cost-effective manner.
- Treat all members with respect and dignity, provide them with appropriate privacy, and treat member disclosures and records confidentially to give members the opportunity to approve or refuse their release.
- Maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide quality member care.
- Contact a Simply case manager if a member exhibits a significant change, is hospitalized, or is admitted to a hospice program.

All providers, including facilities and home health providers shall provide notice to a Simply case manager within 24 hours when they become aware if a member dies, moves out, goes to the hospital , or moves to a new residence.

Simply will delegate submission of the *DCF #2506A Form* to the nursing facilities. Nursing facilities should provide the designated Simply case manager with a copy of the completed form once it has been submitted to DCF.

Assisted living facilities, adult family care homes and nursing homes must retain a copy of the member's Simply plan of care on file.

Assisted living facilities, adult family care homes and adult day care are required to have continual compliance with the Home and Community-Based (HCB) Setting Requirements, which promote and maintain a homelike environment and facilitate community integration. Members residing in assisted living facilities, adult family care homes and adult day care must be offered services with the following options (as applicable) unless medical, physical, or cognitive impairments restrict or limit exercise of these options:

- Choice of:
    - Private or semi-private rooms
    - Roommate for semi-private rooms
    - Locking door to living unit
    - Access to telephone and length of use
    - Eating schedule
    - Activities schedule
    - Participation in facility and community activities
- Ability to have unlimited visitation and snacks as desired

- Ability to prepare snacks as desired and maintain personal sleeping schedule

Simply will terminate providers who are in continuous noncompliance with HCB Setting Requirements.

If a provider is unable to provide covered services on the specific date agreed upon with the case manager, the provider **must** contact the case manager to schedule a new date immediately. If the case manager is not contacted in a timely manner, it may delay adjudication of the claim. All Florida Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) services covered by Simply must be authorized by a Simply case manager.

Providers must complete a Level 2 criminal history background screening to determine whether their subcontractors or any employees or volunteers of their subcontractors who meet the definition of *direct service provider* have disqualifying offenses as provided for in *s. 430.0402 F.S.* as created and *s. 435.04, F.S.* Any subcontractor, employee or volunteer of a subcontractor meeting the definition of a *direct service provider* who has a disqualifying offense is prohibited from providing services to the elderly as set forth in *s. 430.0402, F.S*.

Each provider must sign an affidavit attesting to their compliance with the background requirement. We will keep the affidavit as part of the provider's credentialing files.

Home Health Agencies and Nurse Registries

In order to remain in good standing with Simply, it is expected that agencies providing personal care services and home health services must be 85% EVV-compliant by verifying services using EVV technology. This will help reduce any Fraud, Waste and Abuse situations and facilitate a more transparent monitoring of services provided to our enrollees.

Provider Support Services

We recognize that, to provide quality service to our members, you need the most accurate, up-to-date information. We offer online resource information through our provider website at provider.simplyhealthcareplans.com, provider news at providernews.simplyhealthcareplans.com, or the Provider Inquiry Line, an automated telephonic system at **877-440-3738**. These tools allow you to verify member eligibility and claim status. All you need is one of the following:

- Member ID number
- Member Medicaid number
- Member Social Security number

Submitting Provider demographic data requests and roster submissions through Roster Automation

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers.* **The PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads.** If preferred, providers may continue to use the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today.**

The resources for this process are listed below and available on our website. Visit our website, then *under For Providers*, select **Forms and Guides**. The **Roster Automation Rules of Engagement** and **Roster Automation Standard Template** appear under the *Digital Tools* category:

- **Roster Automation Rules of Engagement** is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.
- **Roster Automation Standard Template:** Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application
Log onto http://Availity.com and select **My Providers > Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screen shot below) and follow the prompts.

Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

Listen to On Demand training by visiting this link.

***** Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health, Inc. who will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates

****** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Concerns, Suggestions, and Complaints

We have a Provider Service Unit to help you with the administration related to providing services to Simply members. Your Provider Service Unit will work to take care of your concerns, suggestions, or complaints in a timely manner. Most issues can be worked out by calling Provider Services at **877-440-3738** between 8 a.m. and 7 p.m. ET.

As a Simply provider, you also have an assigned Provider Relations representative that can provide you additional, in person support or training to address your concerns. You can contact your Provider Relations representative department at **877-440-3738** between 8:30 a.m. and 5 p.m. ET.

Abuse, Neglect, and Exploitation

Report elder abuse, neglect, and exploitation to the statewide Elder Abuse Hotline at **800-96-ABUSE (800-962-2873)**.

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

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

Exploitation of a vulnerable adult means a person who:

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

All direct service providers are required to attend and complete abuse, neglect, and exploitation training. This training can be given by the Department of Children and Families, the local area agency on aging, the Agency for Health Care Administration (AHCA), or training can be accommodated through licensing requirements.

Human Trafficking

The following is a list of potential red flags and indicators of human trafficking to help you recognize the signs. If you see any of these red flags, contact the National Human Trafficking Hotline at **888-373-7888** for specialized victim service referrals or to report the situation.

The presence of these red flags is an indication that further assessment may be necessary to identify a potential human trafficking situation. This list is not exhaustive and represents only a selection of possible indicators. Also, the red flags in this list may not be present in all trafficking cases and are not cumulative. Indicators reference conditions a potential victim might exhibit.

Common work and living conditions:

- Is not free to leave or come and go as they wish
- Is in the commercial sex industry and has a pimp/manager
- Is unpaid, paid very little or paid only through tips
- Works excessively long and/or unusual hours
- Is not allowed breaks or suffers under unusual restrictions at work
- Owes a large debt and is unable to pay it off
- Was recruited through false promises concerning the nature and conditions of their work
- High security measures exist in the work and/or living locations (for example, opaque windows, boarded up windows, bars on windows, barbed wire, security cameras, etc.)

Poor mental health or abnormal behavior:

- Is fearful, anxious, depressed, submissive, tense or nervous/paranoid
- Exhibits unusually fearful or anxious behavior after bringing up law enforcement
- Avoids eye contact

Poor physical health:

- Lacks medical care and/or is denied medical services by employer
- Appears malnourished or shows signs of repeated exposure to harmful chemicals
- Shows signs of physical and/or sexual abuse, physical restraint, confinement, or torture

Lack of control:

- Has few or no personal possessions
- Is not in control of their own money, no financial records, or bank account
- Is not in control of their own identification documents (ID or passport)
- Is not allowed or able to speak for themselves (a third party may insist on being present and/or translating)

Other:

- Claims of just visiting and inability to clarify where they are staying/address
- Lack of knowledge of whereabouts and/or of what city they are in
- Loss of sense of time
- Has numerous inconsistencies in their story

Note: According to federal law, any minor under the age of 18 engaging in commercial sex is a victim of sex trafficking, regardless of the presence of force, fraud, or coercion.

The *Health Insurance Portability and Accountability Act*

The *Health Insurance Portability and Accountability Act* (*HIPAA*), also known as the Kennedy-Kassebaum bill, was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud, and simplifies the administration of health insurance.

We strive to ensure both Simply and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers must have the appropriate procedures implemented to demonstrate compliance with *HIPAA* privacy regulations.

We recognize our responsibility under the *HIPAA* privacy regulations only to request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, you should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, the privacy regulations allow the transfer or sharing of member information, such as a member's medical record, which we may request to conduct business and make decisions about care in order to make an authorization determination or resolve a payment appeal. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at Simply and verify the fax was received appropriately.

Email (unless encrypted) should not be used to transfer files containing member information to Simply (for example, Microsoft Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information, such as medical records. The information should be in a sealed, nylon-reinforced envelope marked confidential and addressed to a specific individual, post office box or department at Simply.

Our voice mail system is secure and password protected. When leaving messages for Simply associates, only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting us, please be prepared to verify your name and address and either your tax identification number, National Provider Identifier or Simply provider number.

Member Records

Providers are required to maintain medical records for each patient in accordance with the medical record requirements below and with *42 CFR 431* and *42 CFR 456*. A permanent medical record will be maintained at the primary care site for every member and be available to the PCP and other physicians. Medical records shall include the quality, quantity, appropriateness, and timeliness of services performed.

Providers are required to have a designated person in charge of medical records. This person's responsibilities include but are not limited to:

- The confidentiality, security, and physical safety of records.
- The timely retrieval of individual records upon request.
- The unique identification of each patient's record.
- The supervision of the collection, processing, maintenance, storage, and appropriate access to the usage of records.
- The maintenance of a predetermined, organized, and secured record format.

Medical Record Standards

Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.

All patient medical records are to reflect all aspects of patient care, including ancillary services. Providers must follow the medical record standards set forth below for each member's medical records as appropriate:

- Include the enrollee's identifying information, including name, enrollee ID number, date of birth, gender and legal guardianship or responsible party if applicable. Include emergency contact information, guardian contact data, if applicable, permissions forms, and copies of assessments, evaluations, and medical and medication information.
- Legal data such as guardianship papers, court orders and release forms
- Maintain each record legibly and in detail.
- Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications and any other health conditions.
- Record the presence or absence of allergies and untoward reactions to drugs, current medications and/or materials in a prominent and consistent location in all clinical records. Note: This information should be verified at each patient encounter and updated whenever new allergies or sensitivities are identified.
- Ensure all entries are dated and signed by the appropriate party.
- Indicate in all entries the chief complaint or purpose of the visit, the objective, diagnoses, and medical findings or impression of the provider.
- Indicate in all entries the studies ordered (for example, lab, X-ray, electrocardiogram) and referral reports.
- Indicate in all entries the therapies administered and prescribed.

- Record all medications prescribed and documentation or medication reconciliation, including any changes in prescription and nonprescription medication with name and dosage when available.
- Include in all entries the name and profession of the provider rendering services (for example, MD, DO), including the provider's signature or initials.
- Include in all entries the disposition, recommendations, instructions to member, evidence of follow-up and outcome of services.
- Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for children under 13 years of age.
- Ensure all records contain an immunization history and documentation of body mass index.
- Ensure all records contain information relating to the member's use of tobacco products and alcohol and/or substance use.
- Ensure all records contain summaries of all emergency services and care and hospital discharges with appropriate and medically indicated follow-up.
- Document referral services in all members' medical records.
- Include all services provided, such as family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Ensure all records reflect the primary language spoken by the member and any translation needs of the member.
- Ensure all records identify members needing communication assistance in the delivery of healthcare services.
- Ensure all records contain documentation of the member being provided with written information concerning their rights regarding advance directives (that is, written instructions for living will or power of attorney) and whether or not they have executed an advance directive:
    - Note: Neither Simply nor any of our contracted providers will require the member to execute or waive an advance directive as a condition of treatment. We will maintain written policies and procedures for advance directives.
- Maintain copies of any advance directives executed by the member.
- Enter significant medical advice given to a patient by phone or online, including medical advice provided after-hours, in the patient's clinical record and appropriately sign or initial.
- Clearly contrast any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research, with entries regarding the provision of nonresearch-related care.
- Review and incorporate all reports, histories, physicals, progress notes and other patient information, such as laboratory reports, X-ray readings, operative reports, and consultations into the record in a timely manner.
- Document a summary of past and current diagnoses or problems, including past procedures if a patient has had multiple visits/admissions, or the clinical record is complex and lengthy.
- Include a notation concerning cigarettes if present for patients 12 years of age and older. Abbreviations and symbols may be appropriate.
- Provide health education to the member.
- Screen patients for substance use and document as part of a prevention evaluation during the following times:
    - Initial contact with a new member
    - Routine physical examinations
    - Initial prenatal contact
    - When the member evidences serious overutilization of medical, surgical, trauma or emergency services
    - When documentation of emergency room visits suggests the need

The following requirements for patients' medical records must also be met:

- **Consultations, referrals, and specialist reports:** Notes from any referrals and consultations must be in the record. Consultation, lab, and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans, including timely notification for the patient or responsible adult party.
- **Emergencies:** All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
- **Hospital discharge summaries:** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for admissions that occurred prior to the patient being enrolled as appropriate (that is, pertinent to the patient's medical condition).
- **Security:** Providers must maintain a written policy and are required to ensure medical records are safeguarded against loss, tampering, alteration, destruction, or unauthorized or inadvertent use.
- **Storage:** Providers must maintain a system for the proper collection, processing, maintenance, storage, retrieval, and distribution of patient's records. Also, the records must be easily accessible to personnel in the provider's office and readily available to authorized personnel any time the organization is open to patients.
- **Release of information:** Written procedures are required for releasing information and obtaining consent for treatment.
- **Documentation:** Documentation is required setting forth the results of medical, preventive, and behavioral health screenings as well as all treatment provided and the outcome of such treatment, including significant medical advice given to a patient by telephone.
- **Multidisciplinary teams:** Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
- **Integration of clinical care**: Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
    - Screening for behavioral health conditions, including those that may be affecting physical healthcare and vice versa, and referral to behavioral health providers when problems are indicated.
    - Screening and referral by behavioral health providers to PCPs when appropriate.
    - Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
    - At least quarterly, or more often if clinically indicated, a summary of the status/progress from the behavioral health provider to the PCP.
    - A written release of information that will permit specific information-sharing between providers.
    - Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.
- **Domestic violence:** Documentation of screening and referral to applicable domestic violence prevention community agencies is required.
- **Consent for psychotherapeutic medications:** Pursuant to statute *F.S. 409.912(13)*, providers must document informed consent from the parent or legal guardian of members younger than 13 who are prescribed psychotherapeutic medications. Providers must also provide the pharmacy with a signed attestation of this documentation with each new prescription for an affected medication; pharmacies are required to obtain and keep these consents on file prior to filing a psychotherapeutic medication.
- **Behavioral health services provided through telemedicine:** Documentation of behavioral health services provided through telemedicine is required. Such documentation must include:
    - A brief explanation of the use of telemedicine in each progress note.

- Documentation of telemedicine equipment used for the particular covered services provided.
- A signed statement from the enrollee or the enrollee's representative indicating the choice to receive services through telemedicine. This statement may be for a set period of treatment or for a one-time visit, as applicable to the service(s) provided.
- For telepsychiatry, the results of the assessment, findings, and practitioner(s) plan for next steps.

Simply will periodically review medical records to ensure compliance with these standards. We'll communicate any deficiencies found during the review and provide education to the provider. When standards are not met, Simply will institute actions, including corrective actions for improvement.

Telemedicine

If we approve you to provide services through telemedicine, you must implement telemedicine fraud and abuse protocols that address:

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

If approved to provide dental services through telemedicine, you may only provide the following medically necessary dental services:

- Oral prophylaxis
- Topical fluoride application
- Oral hygiene instructions

The services listed above performed via telemedicine must be provided by a Florida-licensed dental hygienist at a spoke site with a supervising Florida-licensed dentist located at a hub site. For such dental services, mobile dental units as defined in the Dental Services Coverage and Limitations Handbook may be used as a spoke site.

5 First Line of Defense Against Fraud

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse. Combating fraud, waste, and abuse begins with knowledge and awareness:

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. This includes any act that constitutes fraud under applicable Federal or State law.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** behaviors that are inconsistent with sound financial, business, and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. This includes any member actions that result in unnecessary costs.

To help prevent fraud, waste, and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at fighthealthcarefraud.com.

Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **877-440-3738.**

Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. Providers should instruct their patients who have lost their ID card to inspect their explanation of benefits (EOBs) for any errors and then contact member services if something is incorrect.

Reporting Fraud, Waste and Abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting our fighthealthcarefraud.com education site; at the top of the page, select **Report fraud, waste or abuse** and complete the *Report Waste, Fraud and Abuse* form
- Calling Provider Experience at **877-440-3738**
- Calling Customer Service at **877-440-3738**
- Contacting Medicaid Program Integrity (MPI) within the Agency for Health Care Administration through their webform

Any incident of fraud, waste, or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you

to give as much information as possible. We appreciate your time in referring suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.), include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of Member Fraud, Waste and Abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Relocating to out-of-service Plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a member, include:

- The member's name
- The member's date of birth, Member ID, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste, or abuse

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of provider or member fraud, waste, and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.

- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Instructions for sending paper medical records and/or claims when working with the SIU is found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY** (**282-4548**) for more information.

About Prepayment Review
One method we use to detect FWA is through prepayment claim review. Through a variety of means, certain providers (facilities or professionals), or certain claims submitted by providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or claims activity that indicates the provider is an outlier compared to their/its peers.

Once a claim, or a provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the provider's action(s) may involve FWA, unless exigent circumstances exist, the provider is notified of their placement on prepayment review and given an opportunity to respond.

When a provider is on prepayment review, the provider will be required to submit medical records and any other supporting documentation with each claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the claim under review. The provider will be given the opportunity to request a discussion of their/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of claims submitted by the provider, even if those guidelines are not used for all providers delivering services to Plan members.

The provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose claims are determined to be not payable may make

appropriate corrections and resubmit such claims in accordance with the terms of their *Provider Agreement*, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings
If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily dis-enrolled from our healthcare plan, with state approval.

Offsets
Simply shall be entitled to offset claims and recoup an amount equal to any overpayments ("overpayment amount") or improper payments made by the health plan to provider or facility against any payments due and payable by Simply to provider or facility with respect to any health benefit plan under any contract with our company regardless of the cause. provider or facility shall voluntarily refund the overpayment amount regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the Simply that an overpayment amount is due from provider or facility, provider or facility must refund the overpayment amount within the timeframe specified in letter notifying the provider or facility of the overpayment amount. If the overpayment amount is not received within the timeframe specified in the notice letter, Simply shall be entitled to offset the unpaid portion of the overpayment amount against other claims payments due and payable by Simply to provider or facility under any health benefit plan in accordance with regulatory requirements. Should provider or facility disagree with any determination, provider or facility shall have the right to appeal such determination under Simply procedures set forth in this provider manual, on condition that that such appeal shall not suspend Simply right to recoup the overpayment amount during the appeal process unless required by regulatory requirements. Simply reserves the right to employ a third-party collection agency in the event of non-payment.

6 COVERED HEALTH SERVICES

Summary of Benefits for Simply Long-Term Care Members

We provide the covered services listed below, and we **must** authorize covered services. Any modification to covered services will be communicated through a provider newsletter, provider manual and/or contractual amendment. The provider website has the most up-to-date information on covered services.

The scope of benefits includes the following.

Home and Community Services:

- Adult companion care
- Adult day healthcare
- Assisted living
- Assistive care services
- Attendant care
- Behavioral management
- Care coordination/case management
- Caregiver training
- Home accessibility adaptation
- Home-delivered meals
- Homemaker
- Hospice
- Intermittent and skilled nursing
- Medical equipment and supplies
- Medication administration
- Medication management
- Nursing facility
- Nutritional assessment/risk reduction
- Personal care
- Personal emergency response system (PERS)
- Respite care
- Occupational, physical, respiratory and speech therapies
- Transportation (nonemergency)

Managed Medical Assistance Services (for members who are enrolled in Medicaid with Simply):

- Advanced registered nurse practitioner
- Ambulatory surgical center services
- Assistive care services
- Behavioral health services
- Birth center and licensed midwife services
- Clinic services
- Chiropractic services
- Dental services
- Child health check up
- Immunizations
- Emergency services
- Emergency behavioral health services
- Family planning services and supplies
- Healthy start services
- Hearing services
- Home health services and nursing care
- Hospice services
- Hospital services
- Laboratory and imaging services
- Medical supplies, equipment, prostheses, and orthoses
- Nursing facility services
- Optometric and vision services
- Physician assistant services
- Physician services
- Podiatric services
- Prescribed drug services
- Renal dialysis services
- Therapy service
- Transportation services

Expanded Benefits and Services

We cover additional benefits to eligible members besides what the Florida Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC) program offers. These expanded benefits include the following:

- Up to $6,000 towards transition costs for members transitioning from a nursing home (after meeting the qualification criteria) to the community. ; one lifetime benefit
- Non-medical transportation : unlimited transportation for non-medical purposes to all enrollees so that they can quickly and easily get to community events, health and wellness activities, local dental clinics,

places of worship, libraries, social and group activities, support groups, job coaching, and GED prep courses; up to 25 miles. In addition, we will offer eight one-way rides per month for all enrollees to use for trips in the community to run errands, go to the hair salon or barber shop, etc. up to 25 miles per one-way trip

- Caregiver Transportation — four one-way trips a month for caregivers to visit family in an ALF, AFCH, or nursing facility
- Up to a 10-day bed hold for assisted living and adult family care homes
- Individual therapy sessions for caregivers; 12 sessions per year
- ALF move in basket up to $50 of items to select from; one lifetime benefit

Healthy Living Benefit includes assistive devices/adaptive aides to help members maintain healthy independent living; members can take advantage of this benefit once per lifetime and choose up to two items.

Medical Services

Claims for covered SMMC-LTC services are covered by Simply to the extent they are not covered by Medicare or other insurance or are reimbursed by Medicaid pursuant to Medicaid's Medicare cost sharing policies. These include:

- Durable medical equipment and supplies.
- Home health nurse care.
- Hospice services.
- Inpatient hospital services.
- Occupational, physical and speech therapy services.
- Outpatient hospital/emergency medical services.
- Vision services.

We are responsible for Medicare coinsurance and deductibles as the secondary payer according to Medicaid guidelines. Services not covered by Medicare but offered through the SMMC-LTC program must be authorized by Simply.

All documentation is subject to nationally and generally accepted general industry standards including, but not limited to the American Medical Association (AMA) Current Procedural Terminology (CPT®) code set, the Healthcare Common Procedure Coding System (HCPCS), and the American Hospital Association (AHA) coding clinic guidelines.

In addition to nationally and generally accepted industry standards, the primary authority for all coverage provisions for Medicare is the *Social Security Act*, the *Code of Federal Regulations (CFR)* and the Center for Medicare and Medicaid Services (CMS). Medicaid may be subject to the requirements of your state agency responsible for operating the Medicaid program and/or healthcare laws in your state. In lieu of State-specific rules, Medicaid will defer to Medicare guidelines and other applicable provisions in the Provider Manual.

Laboratory Services

Claims that are submitted for laboratory services subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid CLIA certificate identification number must be reported on a 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent for clinical laboratory services. The CLIA certificate identification number must be submitted in one of the following manners:

Claim format and elements	CLIA number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly HCFA-1500)	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the servicing address is not equal to the billing provider address. The servicing provider address must match the address associated with the CLIA ID entered in field 23.
HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the CLIA ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same *CMS-1500* claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

Providers who have obtained a *CLIA Waiver* or Provider Performed Microscopy Procedure accreditation must include the QW modifier when any CLIA waived laboratory service is reported on a *CMS-1500* claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of CLIA accreditation for the particular test performed. Thus, any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, does not have complete servicing provider demographic information and/or applicable reference laboratory provider demographic information, will be considered incomplete and rejected or denied.

Legally Restricted Services

Authorization/and/or claims for medical services that involve care which are specifically regulated by Federal and State laws may require clinical documentation and specific forms to demonstrate compliance with Federal and State laws in addition to demonstrating medical necessity. No payment for services will be made when the use of state funds for the service is prohibited by law. Simply is required to report concerns of fraud/and/or abuse for services billed that seek reimbursement when the use of public funds is prohibited for that purpose, or for when a Medicaid provider is providing a service in a manner that is prohibited by law.

Emergency Services

Our 24/7 NurseLine is available 24 hours a day, 7 days a week, with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We do **not** discourage members from using the **911** emergency system or deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.

We coordinate emergency response with community services, including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency, and local mental health authorities if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. We will compensate the provider for the screening, evaluations and examination that are reasonable and calculated to assist the healthcare provider in determining whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (that is, whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Simply. If the emergency department is unable to stabilize and release the member, Simply will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Simply concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Member ID Card

Each member is provided an ID card, which identifies the member as a participant in the Simply program. The ID card includes:

- The member's ID number.
- The member's first and last name and middle initial.
- The member's enrollment effective date.
- A toll-free phone number for information and/or authorizations.
- Pharmacy claims processing information.

Please note that possession of a card does not constitute eligibility for coverage. If a Simply member is unable to present their Simply member ID card, please call the member's case manager at **877-440-3738**.

Community Partnerships to Improve Outcomes (CPIO) Program

The health plan partners with community organizations to support the health outcomes of our Medicaid, specialty conditions (HIV/AIDS and SMI), and long-term care members. These organizations focus on key areas such as birth outcomes, mental health of children and adolescents, health related social needs and chronic diseases.

Call Provider Services to receive more information about provider incentive program(s) related to member referrals to these key community organizations.

7 MEMBER ELIGIBILITY

Membership eligibility is determined by the Florida Agency for Health Care Administration (AHCA). Members eligible for Florida Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) enrollment must be:

- 18 years or older.
- Determined by the Florida Comprehensive Assessment and Review for Long-term Care Services (CARES) program to meet nursing facility level of care and be in any of the following programs or eligibility programs: Medicaid-eligible with an income up to the Institutional Care Program (ICP) level as defined by the Florida Department of Children and Families (DCF) (formerly the Department of Health and Rehabilitative Services) or are Medicaid-pending (that is, waiting to find out if financial criteria for Medicaid are met).
- Residing in the SMMC-LTC program service area.

Eligibility Determination

The Florida DCF and/or the federal Social Security Administration determine a person's financial and categorical Medicaid eligibility. Financial eligibility for the SMMC-LTC program is based on Medicaid ICP income and asset level.

The Florida CARES program determines a person's clinical eligibility for the SMMC-LTC program.

It is a provider's responsibility to have processes in place to verify member's ongoing eligibility. Members can lose Medicaid eligibility or move to another LTC health plan, therefore it's the provider's responsibility to check eligibility.

Medicaid Eligibility and Enrollment

Providers cannot request Medicaid enrollment or disenrollment of an enrollee, provide or assist in the completion of Medicaid enrollment or disenrollment requests for an enrollee, or restrict the enrollee's right to disenroll voluntarily in Medicaid in any way (42 CFR 438.56(b)(1), (2), and (3)).

8 MEMBER MANAGEMENT SUPPORT

Identifying and Verifying Long-term Care Members

Upon enrollment, we will send a welcome package to the member. This package includes an introductory letter, a member ID card, a provider directory, and a member handbook. Each Simply member will be identified by presenting a Simply ID card, which includes a member ID number. You can check member eligibility online at provider.simplyhealthcareplans.com using Availity Essentials or by calling us at **877-440-3738**. To verify member eligibility, log on to Availity Essentials at http://Availity.com. From the Availity Essentials homepage, select **Patient Registration > Eligibility & Benefits**.

Communication Access

For member communication access, we:

- Ensure members with low English proficiency have meaningful access to services.
- Make available (upon request) written member materials in large print, on tape and in languages other than English.
- Provide member materials written at the appropriate reading and/or grade level.
- Provide the assistance of an interpreter to communicate with a non-English-speaking member.
- Make Member Services available at **877-440-3738** (TTY **711**) to access translation services for more than 200 languages.

Patient's Bill of Rights and Member Responsibilities

By Florida law, a healthcare provider or healthcare facility is required to recognize member rights while the member is receiving medical care. Additionally, the member is required to respect the healthcare provider's or healthcare facility's right to expect certain behavior. All providers are required to post this summary in their offices. Members may request a copy of the full text of this law from the healthcare provider or healthcare facility.

A member has the right to:

- Be treated with courtesy and respect, with appreciation of their individual dignity, and with protection of their need for privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for their care.
- Know what patient support services are available, including whether an interpreter is available if they do not speak English.
- Know what rules and regulations apply to their conduct.
- Make recommendations about the organization's member rights and responsibilities policy.
- Be given by their healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis regardless of cost or benefit coverage.
- To participate with their healthcare provider in making decisions about their healthcare.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for their care.

- Receive upon request a reasonable estimate of charges for medical care prior to treatment.
- Receive a copy of a reasonably clear and understandable itemized bill and, upon request, have the charges explained.
- Receive impartial access to medical treatment or accommodations regardless of race, national origin, religion, physical handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know whether medical treatment is for purposes of experimental research and give their consent or refusal to participate in such experimental research.
- Be assured confidential handling of medical records and, except when required by law, approve, or refuse their release.
- Express grievances regarding any violation of their rights as stated in Florida law through the grievance procedure of the healthcare provider or healthcare facility that served them and to the appropriate state licensing agency.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage

A member has the responsibility to:

- Provide to their healthcare provider accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to their health to the best of their knowledge.
- Report unexpected changes in their condition to the healthcare provider.
- Report to the healthcare provider whether they understand a suggested course of action and what is expected of them.
- Follow the treatment plan recommended by their healthcare provider.
- Keep appointments and, when unable to do so for any reason, notify the healthcare provider or healthcare facility.
- Be responsible for their actions if refusing treatment or not following the healthcare provider's instructions.
- Ensure the financial obligations of their healthcare are fulfilled as promptly as possible.
- Follow healthcare facility rules and regulations affecting patient care and conduct.
- Members residing in nursing facilities, assisted living facilities, or adult family care homes have patient financial responsibility in accordance with and as determined by the Department of Children and Families.

Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse, and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Simply wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values, and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Simply ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Simply encourages providers to access and use the following resources.

MyDiversePatients.com**:** The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective healthcare to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Simply appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Marketing

Providers are permitted to make available and/or distribute Simply marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all managed care plans with which the provider participates. Providers are also permitted to display posters or other materials in common areas, such as the provider's waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all managed care plan contractual relationships.

We will provide education and outreach and monitor activities to ensure you are aware of and comply with the following guidelines:

- To the extent a provider can assist a recipient in an objective assessment of their needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
- Providers may not:
  - Offer marketing/appointment forms.
  - Make phone calls or direct, urge or attempt to persuade recipients to enroll in a managed care plan based on financial or any other interests of the provider.
  - Mail marketing materials on behalf of a managed care plan.
  - Offer anything of value to induce recipients/enrollees to select them as their provider.
  - Offer inducements to persuade recipients to enroll in a managed care plan.
  - Conduct health screening as a marketing activity.
  - Accept compensation directly or indirectly from a managed care plan for marketing activities.
  - Distribute marketing materials within an exam room setting.
  - Furnish lists of their Medicaid patients or the membership of any managed care plan to a managed care plan
- Providers may:
  - Provide the names of the managed care plans with which they participate.
  - Make available and/or distribute managed care plan marketing materials.
  - Refer their patients to other sources of information such as the managed care plan, the enrollment broker, or the local Medicaid area office.
  - Share information with patients from the agency's website or the CMS website.
  - Announce new or continuing affiliations with the managed care plan through general advertising (for example, radio, television, websites).
  - Make new affiliation announcements within the first 30 calendar days of the new provider agreement.
  - Make one announcement to patients of a new affiliation that names only the managed care plan when the announcement is conveyed through direct mail, email, or phone:
    - Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all managed care plans with which the provider participates.
    - Any affiliation communication materials that include managed care plan-specific information (for example, benefits, formularies) must be prior-approved by the agency.
  - Distribute printed information provided by the managed care plan to their patients comparing the benefits of all of the different managed care plans with which the providers contract.

Provider Gift Policy

Provider personnel are discouraged from taking gifts from members.

9 CASE MANAGEMENT

Role of Case Managers

Simply case managers are responsible for long-term care planning and for developing and carrying out strategies to coordinate and integrate the delivery of medical and long-term care services. Our Case Management department is dedicated to helping members obtain needed services. Each member is automatically assigned to a case manager without any need for a referral. Case managers will:

- Collaborate with physicians and other providers.
- Help members obtain needed services.
- Develop individual care plans.
- Coordinate and integrate acute and long-term care services.
- Visit members in their residences to evaluate and discuss needs.
- Issue authorizations to providers for covered services.
- Promote improvement in the member's quality of life.
- Allocate appropriate health plan resources to the care and treatment of members with chronic diseases.

Case Management Interventions

Case management interventions can be performed by:

- Face-to-face home visits with the member and/or family.
- Telephonic follow-up with the member and/or family by a case manager.
- Providing educational materials.
- Communication with service providers.
- Coordination and integration of acute and long-term care services.

Referrals

The case manager is responsible for determining whether a referral for a long-term care covered service or a change in a long-term care service is appropriate. Authorization of new and/or changed services will be initiated when one of the following conditions applies:

- Services are necessary to address the member's health and/or social service needs.
- The member fails to respond to a current care plan.
- Services are furnished in a manner not primarily intended for the convenience of the member, the member's caregiver, or the provider.

For Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) program members with Medicare: All referrals for services not covered by Medicare require authorization by the member's case manager. Members requiring a Medicare-covered service must access the benefit through the Medicare fee-for-service program or through their Medicare health maintenance organization.

We must authorize SMMC-LTC services. Contact the member's case manager for authorization. The member and provider will be given the assigned Case Manager's cell phone number or contact the case manager at **877-440-3738**.

The member's case manager may send you the following documents to help you provide covered services:

- *New Service Form* — used to initiate new services; usually used for home health, emergency response or meal providers
- *Hold/Resume Form* — used to place services on hold and resume services; usually used for home health, emergency response or meal providers
- *Change of Service Form* — used to change the frequency and duration of a service

- *Termination Form* — notifies providers to end services; usually used for meal providers
- *Authorization Form* — authorizes provider payment for covered services

Hospital Admissions

When you learn a member requires hospital admission or has been admitted to a hospital, an assisted living facility, home health care or nursing home, or is under the care of another provider, you should notify the member's case manager. You must notify the Simply case manager in writing within 24 hours if a member is hospitalized, discharged, moves out or is deceased. We will waive the bed-hold days for assisted living facility and nursing home providers if not provided with proper notification of a member's relocation for inpatient stay, hospice admission, or temporary or permanent move. The Simply case manager will proactively help the member with discharge planning needs prior to returning to the community by collaborating with the family, inpatient discharge planner and facility.

Medicare, MMA, or commercial coverage is the primary payer for inpatient hospital services. For questions regarding services, please contact the case manager at **877-440-3738**.

The following providers are required to have 24-hour service:

- Assisted living facilities
- Adult family care homes
- Hospice centers
- Emergency response systems
- Nursing homes

Physicians will provide advice and assess care as appropriate for each member's medical condition. Emergent conditions will be referred to the nearest emergency room.

Condition Care

The Condition Care (CNDC) programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. The program includes a holistic, focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member self-empowerment, and the ability to manage more than one condition to meet the changing healthcare needs of our member population.

Condition Care includes programs for Alzheimer's and dementia.

Program Features

- Proactive identification processes
- Program content is based on evidenced-based clinical practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning
- Offers continuous patient self-management education, including primary prevention, coaching related by healthy behaviors and compliance/monitoring, as well and case/care management for high-risk members
- Ongoing communication with providers regarding patient status

Our condition care program is based on nationally approved clinical practice guidelines located at provider.simplyhealthcareplans.com. A copy of the guidelines can be printed from the website.

Who Is Eligible?

All members are eligible for the CNDC services for which their conditions correspond.

CNDC Provider Rights and Responsibilities
The provider has the right to:

- Have information about Simply, including provided programs and services, our staff, and our staff's qualifications and contractual relationships.
- Decline to participate in or work with the Simply programs and services for their patients, depending on contractual requirements.
- Be informed of how Simply coordinated interventions with treatment plans for individual patients.
- Know how to contact the person responsible for managing and communicating with the provider's patients.
- Be supported by the organization to make decisions interactively with patients regarding their healthcare.
- Receive courteous and respectful treatment from Simply staff.
- Communicate complaints about CNDC as outlined in the Simply provider complaint and grievance procedure

Hours of Operation
Our condition care case managers are registered nurses are available Monday to Friday, 8:30 a.m. to 5:30 p.m. ET. Confidential voice mail is available 24 hours a day.

Contact Information
Please call **888-830-4300** to reach a condition care case manager. Additional information about condition care can be obtained by visiting provider.simplyhealthcareplans.com. Members can obtain information about our CNDC by visiting simplyhealthcareplans.com/Medicaid or calling **888-830-4300**.

Enrollee Advisory Committee

Simply maintains an enrollee advisory committee that considers LTC member issues and obtains periodic feedback from LTC members on satisfaction with care, problem notification and suggestions for improving the service delivery system (*42 CFR 438.110(a)*).

The committee assesses, and addresses concerns around, the quality and quantity of services as well as the courtesy and knowledge of providers. In addition to assessing member satisfaction with Simply and its LTC providers, the enrollee advisory committee also enables the following:

- Identifying health education needs of the membership
- Educating members about their rights and responsibilities, their benefits, and how to file a grievance or appeal.
- Identifying process improvement opportunities.
- Identification of problems
- Suggestions for improving the service delivery system.

The enrollee advisory meeting is held at least twice annually.

10 QUALITY MANAGEMENT

Quality Improvement Program

Simply's Quality Improvement Program (QI Program) is an ongoing, comprehensive, and integrated system that defines how we support quality objectively. The program also systematically monitors and evaluates the quality, safety and appropriateness of care and services offered by the health network and identifies and acts on opportunities for improvement. A staff member with five or more years of experience and/or training in working with elders and/or individuals with disabilities is appointed to the Quality Management Committee.

The purpose of the QI Program is to:

- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable care and services.
- Identify and implement strategies to improve the quality, appropriateness, and accessibility of member healthcare.
- Facilitate organization-wide integration of quality management principles.

The overall goal of the QI Program is to improve the quality and safety of care and services provided to members through Simply's network of providers and our programs and services. All QI Program goals are reviewed annually and revised as needed. Goals are primarily identified through:

- Ongoing activities to monitor care and service delivery.
- Issues identified by tracking and trending data over time.
- Issues/outcomes identified in the previous year's *QM Program Evaluation*.
- A demographic and morbidity analysis of member age, gender and most frequently diagnosed disease categories (both inpatient and outpatient).
- Internal process reviews.
- Accreditation, regulatory and contractual standards.

The Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) program addresses the needs of all long-term care members and promotes improvement of quality of life. As part of the Simply QI Program, we identify potential problematic areas for members and implement strategies for improvement. Our case management team helps ensure quality-of-life enhancements for members by monitoring quality, appropriateness, and effectiveness of members' care.

Our long-term care program relies on members, as well as their caregivers and providers, to help improve their quality of life. Provider communications about a member's daily living needs provide important information to case managers and help with quality improvement activities.

For members living at home, in an assisted living facility, adult family care home or in a nursing home, case managers promote members' quality of life by developing members' spirit, facilitating their freedom of choice by encouraging their individuality, promoting their independence, personalizing their services, and helping them maintain their dignity.

Measuring Quality Performance

Simply's QI Program strives to enhance quality of care and emphasizes improving the quality of patient outcomes, including establishing metrics for monitoring the quality and performance of each participating provider. Provider performance is assessed through medical record reviews, site reviews, peer reviews,

satisfaction surveys, performance improvement projects and provider -specific metrics. Providers are required to support and meet QI Program standards.

Potential Quality of Care Concerns

Simply's QI Program includes review of quality-of-care issues identified for all care settings. QM staff use member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members. Potential quality of care investigations are tied into the peer review and credentialing/recredentialing processes.

Provider Orientation, Monitoring and Education

Provider Relations conducts initial and ongoing in-services to providers. The in-service includes an overview of long-term care and member eligibility, the case manager's role, authorization, and billing and contract information. Educational sessions can be scheduled at your convenience.

Simply conducts monitoring visits in accordance with the Simply credentialing and recredentialing policy. We will provide a thorough explanation of the monitoring and review findings during an exit conference on the day of the review. If your schedule does not allow for sufficient time on the day of the review, a follow-up appointment can be scheduled.

Satisfaction Surveys

Simply conducts an annual survey to assess provider satisfaction with provider enrollment, communications, credentialing, complaint resolution, claims processing, claims reimbursement, grievance and appeals, utilization management processes, and case management processes.

Simply conducts the state of Florida's required standardized Provider Satisfaction Survey Tool. The results of this survey are provided to AHCA each calendar year.

Simply also conducts the Consumer Assessment of Healthcare Providers and Systems Community-Based Services Survey (CAHPS® HCBS). This survey assesses our LTC members' experiences with our health plan and their LTC providers. Core questions cover topics such as provider reliability and helpfulness, provider communication, case manager helpfulness, choice of services, personal safety, community inclusion and empowerment.

Provider Data Sharing

Provider data sharing reports are developed for providers and are used by Simply in evaluating provider performance during credentialing and recredentialing procedures and recontracting decisions.

Provider data sharing reports contain trended information from documentation reviews, member input, quality-of-care issues, contract compliance and comparisons with other providers in the same specialty.

Providers must share their performance data with us upon request and cooperate with quality improvement activities.

Credentialing

Credentialing Requirements

To become a participating Simply provider, you must be eligible to enroll in the Medicaid program and must hold a current, unrestricted license issued by the state. We are authorized to take whatever steps necessary to ensure each provider is recognized by the state Medicaid program, including its choice of counseling/enrollment broker contractor(s) as a participating provider of Simply, and the provider's submission of encounter data is

accepted by the Florida Medicaid Management Information Systems and/or the state's encounter data warehouse. You must also comply with our credentialing criteria and submit all additionally requested information, including ownership and control information. To initiate the credentialing process, you must submit a complete *Credentialing Application* (individuals) or a *Florida Long-term Care Application* and all required attachments.

Credentialing Procedures

Our credentialing program includes, but is not limited to, the following types of long-term care providers:

- Nursing home and hospice providers
- Assisted living, adult family care homes and adult day health services
- Home health, nurse registry, homemaker, and companion agencies
- Medical equipment and supplies, home accessibility adaptation services and personal emergency response services (PERS)
- Physical, occupational, respiratory and speech language therapists
- Home-delivered meals and nutritional assessment/risk-reduction services

Simply's discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Simply's discretion in any way to amend, change or suspend any aspect of Simply's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or Health Delivery Organizations (HDOs) who seek to provide healthcare services to members. Simply further retains the right to approve, suspend, or terminate individual physicians and healthcare professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Simply
    - An independent relationship exists when Simply directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners; and
3. Practitioners who provide care to members under Simply's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
    - That are part of Simply's primary network and include Simply members who reside in the rental network area.
    - That are specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Simply credentials the following licensed/state certified independent health care practitioners:

- Medical doctors (MD)
- Doctors of osteopathic medicine (DO)
- Doctors of podiatry

- Chiropractors
- Optometrists providing health services covered under the health benefit plan
- Doctors of dentistry providing Health Services covered under the health benefit plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the health benefit plan
- Telemedicine practitioners who provide treatment services under the health benefit plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified behavioral analysts
- Certified addiction counselors
- Substance use disorder practitioners

Simply credentials the following HDOs:

- Assisted living facilities
- Adult family care homes
- Adult day care
- Home delivered meal
- Hospice
- Personal emergency response
- Hospitals
- Home health agencies
- Homemaker & companion agencies
- Skilled nursing facilities (nursing homes)
- Ambulatory surgical centers
- Behavioral health facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult family care/foster care homes
    - Ambulatory detox
    - Community mental health centers (CMHC)
    - Crisis stabilization units
    - Intensive family intervention services
    - Intensive outpatient – mental health and/or substance use disorder
    - Methadone maintenance clinics
    - Outpatient mental health clinics

    - Outpatient substance use disorder clinics
    - Partial hospitalization – mental health and/or substance use disorder
    - Residential treatment centers (RTC) – psychiatric and/or substance use disorder
- Birthing centers
- Home infusion therapy when not associated with another currently credentialed HDO
- Durable medical equipment providers

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End stage renal disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission)
- Portable X-ray Suppliers (CMS Certification)
- Home infusion therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)
- Orthotics and prosthetics suppliers (American Board for Certification in Orthotics and Prosthetics [ABCOP] or Board of Certification/Accreditation [BOC] or The National Examining Board of Ocularists [NEBO])

Credentials committee

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Simply's networks or plan programs is conducted by a peer review body, known as Simply's credentials committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of medical and credentialing policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Simply affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Simply medical director designee and the vice-chair must be a lead medical officer or an Simply medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine [family medicine or internal medicine]; surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (for example, Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more networks or plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Simply's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Simply may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination policy

Simply will not discriminate against any applicant for participation in its plan programs or provider networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Simply will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Simply will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Simply will take appropriate action to track and eliminate those practices.

Initial credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Simply when applying for initial participation in one or more of Simply's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at CAQH.org.

Simply will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Simply will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification element
License to practice in the state(s) in which the practitioner will be treating members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ or ACHC accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance

Verification element
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Simply credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

HDOs

New HDO applicants will submit a standardized application to Simply for review. If the candidate meets Simply screening criteria, the credentialing process will commence. To assess whether network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Simply Credentialing Program Standards" section, all network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Simply may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Ongoing sanction monitoring

To support certain credentialing standards between the re-credentialing cycles, Simply has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing boards/agencies
- Member/customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Simply departments
- Any other information received from sources deemed reliable by Simply.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Appeals process

Simply has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Simply's networks or plan programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Simply may wish to terminate practitioners or HDOs. Simply also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Simply's networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Simply will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Simply's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Simply's networks or plan programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Simply's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

Reporting requirements

When Simply takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its networks or plan programs, Simply may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Simply credentialing program standards

Eligibility criteria

A. Healthcare practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in

which he or she will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state; and

4. Meet the education, training and certification criteria as required by Simply.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Simply's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.
    b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Simply education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Simply review and approval. Reports submitted by delegates to Simply must contain sufficient documentation to support the above alternatives, as determined by Simply.
5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Accreditation Commission for Health Care (ACHC) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For genetic counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license genetic counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for selecting practitioners

New applicants (credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who treat members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Simply upon receipt of the required DEA/CDS registration.
    d. Simply will verify the appropriate DEA/CDS registration via standard sources.
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the network.
11. Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Simply's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:
    a. It can be verified that the applicant's application is pending; and
    b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
    c. The applicant agrees to notify Simply upon receipt of the required DEA registration; and
    d. Simply will verify the appropriate DEA/CDS registration via standard sources; and
    e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. Controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. He or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

12. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
13. No history of or current use of illegal drugs or history of or current substance use disorder.
14. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
15. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
16. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
17. A minimum of the past 10 years of malpractice claims history is reviewed.
18. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Simply's network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
19. No involuntary terminations from an HMO or PPO.
20. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;

h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
   a. Master or doctoral degree in social work.
   b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
   c. Licensure to practice independently.
2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
   a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
   c. Practitioners with PhD training as a clinical psychologist can be reviewed.
   d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
   e. Licensure to practice independently or in states without licensure or certification:
      i. Marriage & Family Therapists with a master's degree or higher:
         a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
      ii. Mental Health Counselors with a master's degree or higher:
         a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
   a. Master's or doctoral degree in a mental health discipline.
   b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
   c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE (documentation of eligibility of ACPE required).
3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse

Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.

c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

5. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
   c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
6. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training;
      ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.
7. Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Simply Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      (b) Meet examination requirements for licensure as determined by the licensing state.
8. Process, requirements and Verification – Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional

education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.

c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Simply procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
    ii. American Academy of Nurse Practitioners – Certification Program;
    iii. National Certification Corporation;
    iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
    v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
    vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care.

These certifications must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Simply is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in Simply's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in Simply's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Certified Nurse Midwives:

a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Simply procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:
    iv. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    v. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Simply is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
g. The CNM applicant will undergo the standard credentialing process outlined in Simply's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
h. Upon completion of the credentialing process, the CNM may be listed in Simply's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
    i. CNMs will be clearly identified:
    ii. On the credentialing file;
    iii. At presentation to the CC; and
    iv. Upon notification to network services and to the provider database.

10. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Simply procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Simply is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Simply Health Plan and submitted for individual review by the CC.
    f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
    g. The PA applicant will undergo the standard credentialing process outlined in Simply's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
    h. Upon completion of the credentialing process, the PA may be listed in Simply provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
        i. PA's will be clearly identified:
        i. On the credentialing file;
        ii. At presentation to the CC; and
        iii. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Simply's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately

ineligible for participation in the applicable government programs or provider Networks as well as Simply's other credentialed provider Networks.

4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Simply standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Simply may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Simply may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for member access need only when the CC review indicates compliance with Simply standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Simply standards.

1. General Criteria for HDOs:
    a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
    b. Valid and current Medicare certification.
    c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Simply's plan programs or provider networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider networks as well as Simply's other credentialed provider networks.
    d. Liability insurance acceptable to Simply.
    e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Simply's quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by provider type:

HDO type and simply approved accrediting agent(s)

Facility type (medical care)	Acceptable accrediting agencies
Acute Care Hospital	CIQH, TCT, DNV NIAHO, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility type (behavioral healthcare)	Acceptable accrediting agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC

Facility type (behavioral healthcare)	Acceptable accrediting agencies
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

Facility type (behavioral health care - rehabilitation)	Acceptable accrediting agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

Delegated Credentialing

Provider groups with strong credentialing programs that meet Simply credentialing standards may be evaluated for delegation. As part of this process, we will conduct a predelegation assessment of a group's credentialing policy and program, as well as an onsite evaluation of credentialing files.

A passing score is considered an overall average of 90% compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation.

We may waive the need for the predelegation onsite audit if the group's credentialing program is National Committee for Quality Assurance-certified for all credentialing and recredentialing elements. We are responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

Provider Temporary Enrollment

Providers that do not have a Medicaid ID and render services during a disaster or emergency declared by a Governor's Executive Order, as confirmed by the Agency, must complete the Agency's provisional (temporary) enrollment process to obtain a provider identification number for services rendered to enrollees.

Quality Enhancement Programs

Our case managers recommend the below quality enhancement programs for our enrollees:

Safety Concerns in the Home and Fall Prevention
All Simply LTC case managers receive training regarding the member's risk of falls and conduct a home fall risk assessment as a part of the comprehensive assessment.

Simply LTC case managers conducts an assessment of the member's home environment that will result in product recommendations tailored to the member to reduce the risk of falls.
Key to identifying safety issues and preventing falls is education. The LTC case manager will have the tools and resources to provide educational materials and make connections with community resources when needed.

Simply has also created a Caregiver Support Program, which provides services and supports for the caregiver. This program includes caregiver training that supports home safety for the member.

End of Life Issues and Advance Directives
All Simply LTC case managers receive training regarding end-of-life issues and the importance of obtaining advance directives. The case manager uses this knowledge to assess and educate the member about these important issues.

Key to ensuring members understand their options and the importance of having advance directives in place is education. The LTC case manager will have the tools and resources to provide educational materials and make connections with community resources when needed.

Healthy Rewards — Healthy Behaviors Rewards Program

We offer programs to SMMC MMA members who want to stop smoking, lose weight, or address any drug use problems, and we reward members who join and meet certain goals. Our Healthy Behaviors Rewards programs include:

- Smoking/Tobacco cessation program.
- Weight management program.
- Alcohol and substance use program.
- Health education advisory committee.
- Maternal child program.
- SBIRT (Screening, Brief, Intervention, Referral, and Treatment) screening
- HIV Management

Setting Healthy Goals
The Simply Healthy Behaviors Rewards program exists to help our members. Together, we make a plan and set goals to beat tough health issues. For example, for alcohol and substance use and smoking cessation, we offer help and support through coaching and participation in community groups. For weight management and nutrition, we offer help and support from a nurse in making healthy exercise and food choices.

Resources and Tools
The Florida Quitline is a toll-free, telephone-based tobacco use cessation service. Any person living in Florida who wants to try to quit smoking can use the Quitline. The following services are available through the Quitline:

- Counseling sessions
- Self-help materials
- Counseling and materials in English and Spanish
- Translation service for other languages

- Pharmacotherapy assistance
- TDD service for the deaf or hard of hearing

Online Resources

Website	Resource Information
smokefree.gov	A cravings journal, information on medicines to help members quit, *Pathways to Freedom for African Americans* and *Guia para Dejar de Fumar* (Spanish resource)
ffsonline.org	American Lung Association's Freedom from Smoking Program
cancer.gov/cancertopics/factsheet/tobacco/cessation	Additional resources, including support to quit, Information about why to quit and how to get help

Online Continuing Education for Physicians

Providers can receive continuing education training online through these resources:

- MAHP Oral Health and Tobacco Cessation Educational Program for Primary Care Providers
- Treating Tobacco Use and Dependence through the Wisconsin Medical School
- medscape.com
- Tobacco Cessation Podcasts for Physicians

Printed Resources for Members

We offer the following printed resources you can share with members:

- You Can Quit Smoking
- Tobacco Use — Breaking the Habit
- Tobacco Use — Reasons to Quit

Printed Resources for Providers

- Quick Reference Guide: Treating Tobacco Use and Dependence

All member materials are available on the member website, and provider materials are on the provider website.

11 MEDICAL MANAGEMENT

Medical Review Criteria

Simply uses nationally recognized, evidence based *Medical Policies* and *Clinical Utilization Management Guidelines*. These policies are publicly available on our website and can be obtained in hard copy by written request. Their purpose is to help you provide quality care by reducing inappropriate use of medical resources.

McKesson InterQual criteria will continue to be used when no specific *Medical Policies* exist. In all cases, Medicaid contracts or CMS requirements supersede both McKesson InterQual and *Medical Policy* criteria:

- **Medically necessary** services include medical, allied, or long-term care, goods or services furnished or ordered to meet the following conditions:
  - Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain (This requirement applies only to recipients age 21 years or older)
  - Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
  - Consistent with the generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational

- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
- Furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker, or the provider

- For those services furnished in a hospital on an inpatient basis, medical necessity means appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
- The fact that a provider has prescribed, recommended, or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Precertification/Notification Process

Simply may require members to seek a referral from their PCP prior to accessing nonemergency specialty physical health services.

Precertification is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered and a member's severity of illness, medical history, and previous treatment to determine the medical necessity and appropriateness of a given coverage request.

Prospective means the coverage request occurred prior to the service being provided.

Notification is defined as a faxed, telephonic, or electronic communication received from a provider informing Simply of the intent to render covered medical services to a member. There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified. Notification should be provided prior to rendering services. For services that are emergent or urgent, notification should be given within 24 hours or the next business day. Failure to comply with notification rules will result in an administrative denial.

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative Denial
Administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical information when requested. Appeals for administrative denials must address the reason for the denial (that is, why precertification was not obtained or why clinical was not submitted).

If Simply overturns its administrative decision, the case will be reviewed for medical necessity, and if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

Authorizations that fall under the categories below will all be reviewed by a plan medical director for medical necessity.

A request for authorization of any medically necessary service for a member under 21 years of age when:

- The service is not listed in the service-specific *Florida Medicaid Coverage and Limitations Handbook*, Florida *Medicaid Coverage Policy*, or the associated *Florida Medicaid Fee Schedule.*
- The service is not a covered service of the plan.
- The amount, frequency or duration of the service exceeds the limitations specified in the service specific handbook.

- The corresponding fee schedule can be requested in the same manner as noted above.

Access to UM Staff:

- UM staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. Staff are available Monday to Friday, 8:30 a.m. to 5 p.m. ET.
- Staff can receive inbound communication regarding UM issues after normal business hours at **877-440-3738**. Our after-hours answering service will ensure providers our connected to one of our managers, nurses, or the medical director as appropriate.
- Staff identify themselves by first name/first initial of last name, title and organization name when initiating or returning calls regarding UM Issues.
- TDD/TTY services are available by dialing **711**.
- Language assistance, such as interpreter services, is available by calling Provider Services at **877-440-3738**.

12 MEMBER APPEAL AND GRIEVANCES PROCEDURES

Members have the right to examine the case file, including medical records and any other material to be considered during the process. They may ask for a free copy of the guidelines, records or other information used to make all decisions related to the appeal. The request can be made before, during or after the appeal.

What you should know:

- If coverage of the service you asked for has been denied, limited, reduced, suspended, or terminated, you must ask for an appeal within 60 days of the date on the letter that said we would not pay for the service.
- You can ask for an expedited appeal if you think the member needs the services for an emergency or life-threatening illness.
- You can ask us to send you more information to help you understand why we would not pay for the service you requested.
- We only have one level of member appeal. During the appeal, a doctor who has not reviewed the case before will look at it and make a decision.

The Appeal Process

An appeal may be filed orally or in writing within 60 calendar days of receipt of our notice of adverse benefit determination.

There are five ways to submit an appeal:

1. **Appeal Online via Availity Essentials:**
   - Request an appeal using Interactive Care Reviewer (ICR), our digital authorization application for any eligible denied authorization affiliated with your tax id/organization at http://Availity.com. From the Availity Essentials home page, select **Patient Registration**, then select **Authorizations & Referrals** to locate the case:
     - To request an appeal through ICR, you need to have the Authorization Referral Request role assignment on Availity. Your organization's Availity administrator can give you access to this role.
   - You can upload supporting documentation through the authorization application and will receive acknowledgement of your submission.
   - To be eligible the case must be in a denied status. You can also request a clinical appeal through ICR for cases submitted by phone and fax.
2. **Verbally: Call Provider Services** at **877-440-3738**

3. Email us at flmedicaidgrievances@anthem.com.
4. Send a fax to **866-216-3482**.
5. Written: Mail all required documentation:
    - Appeal letters and other related clinical information should be sent to:
      Simply Healthcare Plans, Inc.
      Medical Appeals
      P.O. Box 62429
      Virginia Beach, VA 23466-2429

Member Rights in the Appeals Process

Please share this information with your Simply patients to educate them on their rights in the appeals process:

- If you call us, we will send you an appeal form. If you want to have someone else help you with the appeal process, let us know, and we will send you a form for that as well. Fill out the whole form and mail it back to us. We can also help you fill out the form when we talk to you on the phone.
- When we get your letter or appeal form, we will send you a letter within five business days to tell you we got your appeal.
- You may ask for a free copy of the guidelines, records or other information used to make this decision.
- We will tell you what the doctor decides within 30 calendar days of getting your appeal (or 48 hours for expedited appeals).
- If we reduce coverage for a service you are receiving right now and you want to continue to get the service during your appeal, you can call us to ask for it. You must call within 10 days of the date of the initial denial letter mailed to you that tells you we will not pay for the service.
- If you have more information to give us, you can bring it to us in person or write to us at the address below. Also, you can look at your medical records and information on this decision before and during the appeal process.
- The time frame for a grievance or appeal may be extended up to 14 calendar days if you ask for an extension or we find additional information is needed and the delay is in your interest. If the time frame is extended other than at your request, we will call you on the same day and notify you in writing within two calendar days of the determination of the reason for the delay. If you disagree with the extension, you can request a grievance.
- If you have a special need, we will give you additional help to file your appeal. Please call **877-440-3738** (TTY **711**) to ask for help.
- If you have any questions or need help, please call the Member Services department toll free at **877-440-3738** (TTY **711**). Member Services can assist you Monday to Friday, 8 a.m. to 7 p.m. ET, excluding holidays.

Medical Appeals Address

Mail all of your medical information about the service with your letter to:

Simply Healthcare Plans, Inc.
Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

State Fair Hearing Process

A member may seek a Medicaid fair hearing any time up to 120 days after receiving Simply's notice of plan appeal resolution. The member must finish the appeal process first.

To have services continued, the member must request a fair hearing within 10 days from the date of the denial letter or within 10 calendar days after the intended effective date of the action, whichever is later. The member may have to pay for services received if a decision is made to uphold our decision.

The Medicaid Hearing Unit is not part of Simply; it looks at appeals of Medicaid members who live in Florida. We will give the office information about the case, including the information you have given us.

You or the member can contact the Medicaid Hearing Unit at:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
877-254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

Urgent or Expedited Appeals:

- You, with the member's consent, or the member can ask for an urgent or expedited appeal if you think the time frame for a standard appeal process could seriously jeopardize the member' life, health, or ability to attain, maintain or regain maximum function.
- You or the member can also call Member Services toll free at **877-440-3738** (TTY **711**) to ask for an expedited appeal.
- We will resolve each expedited appeal and provide notice to you and the member as quickly as the member's health condition requires within state-established time frames not to exceed 48 hours after we receive the appeal request. If we deny your request for expedited appeal, we will notify you that the appeal will be transferred to the time frame for standard resolution. If the member disagrees with the downgrade to a standard appeal the member can file a grievance.

For more information on the member grievance and appeals procedures, please refer the member to their *Simply Member Handbook.*

Complaints and Grievances

Please share this information with your Simply patients to educate them on their rights in the grievance process.

I have a concern I would like to report.
Simply has a process to solve complaints and grievances. If you have a concern that is easy to solve and can be resolved within 24 hours, Member Services will help you. If your concern can't be handled within 24 hours and needs to be looked at by our grievance coordinator, your call will be transferred to the grievance and appeals coordinator.

How do I let Simply know about my concern?
A complaint or grievance must be given by phone or in writing any time after the event happened. To file a complaint or grievance with a grievance and appeals coordinator:

1. Call Member Services at **877-440-3738** (TTY **711**) between 8 a.m. and 7 p.m. ET.

2. Write us a letter regarding your concern. Mail it to:
   Simply Healthcare Plans, Inc.
   Grievance and Appeals Coordinator
   P.O. Box 62429
   Virginia Beach, VA 23466-2429
3. Fax Number: **866-216-3482**
4. Email us at flmedicaidgrievances@anthem.com.

You can have someone else help you with the grievance process. This person can be any of the following:

- A family member
- A friend
- Your doctor
- A lawyer

Write this person's name on the grievance form.

If you need help filing the complaint, Simply can help. Call Member Services at **877-440-3738** (TTY **711**) and a grievance and appeals coordinator will help you. Once Simply gets your grievance (oral or written), we will send you a letter within five business days. This letter will tell you the date we got your grievance.

What happens if I have additional information?
If you have more information you want us to have:

1. Mail it to:
   Simply Healthcare Plans, Inc.
   Grievance and Appeals Coordinator
   P.O. Box 62429
   Virginia Beach, VA 23466-2429
2. Fax number: **866-216-3482**
3. The grievance and appeals coordinator will call you when you send in your grievance.
4. Call the grievance and appeals coordinator at **877-440-3738** (TTY **711**).

What happens next?
The grievance coordinator will review your concern. If more information is needed or you have asked to talk to the coordinator, they will call you. Clinical staff look at medical concerns. Simply will tell you the decision of your grievance within 30 calendar days from the date we got your grievance.

What happens if I want an extension?
Although Simply normally will resolve your concern within 30 calendar days, there are times when an extension is needed. Simply may extend the time it takes to resolve your concern up to 14 calendar days if:

- You request an extension.
- Simply needs additional information and we believe by extending the time it is in your best interest. If you disagree with the extension, you can request a grievance.

Simply will call you the same day and let you know in writing, within two calendar days of our identification, that a grievance extension is needed.

Medical Appeals

There may be times when Simply says it will not pay, in whole or in part, for care that your doctor has asked for. If we do this, you can appeal the decision. A medical appeal is when you ask Simply to look again at the care your doctor asked for and we said we would not pay for. You must file for an appeal within 60 calendar days

from the date on the (*Notice of Adverse Determination*) letter that says we will not pay for a service. Simply will not act differently toward you or the doctor who helped file an appeal.

I want to ask for an appeal. How do I do it?
An appeal may be filed verbally by phone or in writing. This needs to be within 60 calendar days of when you get the notice of adverse benefit determination. There are four ways to file an appeal:

1. Write and ask to appeal. Mail the appeal request and all medical information to:
   Simply Healthcare Plans, Inc.
   Grievance and Appeals Coordinator
   P.O. Box 62429
   Virginia Beach, VA 23466-2429
2. Call the grievance and appeal coordinator toll-free at **877-440-3738** (TTY **711**).
3. Email us at flmedicaidgrievances@anthem.com.
4. Send a fax to **866-216-3482**.

What else do I need to know?
When we get your letter, we will send you a letter within five business days. This will tell you we got your appeal. You may also ask for a free copy of the guidelines, records or other information used to make this ruling. We'll tell you what the ruling is within 30 calendar days of getting your appeal request.

What if I have more information I want you to have?
If you have more information to give us, mail it to the Medical Appeals address or fax it to number above. Also, you can look at your medical records and information on this ruling before and during the appeal process. The time frame for an appeal may be extended up to 14 calendar days if:

- You ask for an extension.
- Simply finds additional information is needed, and the delay is in your interest. If you disagree with the extension, you can request a grievance.

If the time frame is prolonged other than at your request, Simply will call you on the same day and let you know in writing within two calendar days of when the ruling is made.

If you have a special need, we will give you extra help to file your appeal. Please call Member Services at **877-440-3738** (TTY **711**) Monday to Friday, 8 a.m. to 7 p.m. ET.

What can I do if I think I need an urgent or expedited appeal?
You or your doctor or someone on your behalf can ask for an urgent or expedited appeal if:

- You think the time frame for a standard appeal process could seriously harm your life or health or ability to attain, maintain or regain maximum function, based on a prudent layperson's judgment.
- In the opinion of your doctor who has knowledge of your medical condition, a standard appeal would subject you to severe pain that cannot be well managed without the care or treatment that is the subject of the request.

You can also ask for an expedited appeal by calling Member Services toll-free at **877-440-3738** (TTY **711**) Monday to Friday, 8 a.m. to 7 p.m. ET.

If you have any questions, need help, or would like to talk to the grievance and appeals coordinator, call Member Services toll-free at **877-440-3738** (TTY **711**) Monday to Friday, 8 a.m. to 7 p.m. ET.

We must respond to you by phone within 48 hours after we receive the expedited appeal request, whether the appeal was made verbally by phone or in writing. If the request for an expedited appeal is denied:

- The appeal will be transferred to the time frame for standard resolution.
- You will be notified verbally on the same day and with a written notice within two calendar days.

What if my healthcare was reduced, postponed, or ended, and I want to keep getting healthcare while my appeal is in review?

Call Member Services if you would like to keep your benefits during your appeal. Simply will continue your benefits if:

1. You or your authorized representative file an appeal with Simply regarding the decision either:
   a. Within 10 calendar days after the notice of the adverse action is mailed.
   b. Within 10 calendar days after the intended effective date of the action, whichever is later.
2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
3. The services were ordered by an authorized provider.
4. The original period covered by the original authorization has not expired.
5. You request extension of benefits.

If you meet these requirements, Simply will approve the service until one of the following happens:

1. You withdraw the appeal.
2. Ten calendar days pass after Simply sends you the notice of resolution of the appeal against you, unless within those 10 calendar days you have requested a Medicaid fair hearing with continuation of benefits.
3. The Medicaid fair hearing office issues a hearing decision adverse to you.
4. The time period or service limits of a previously authorized service have been met.

If the first level appeal is upheld or the state fair hearing agrees with us, you may have to pay for the care you got during the appeal.

What can I do if Simply still will not pay?

You have a right to ask for a state fair hearing. You must complete the appeal process before you ask for the fair hearing. If you ask for a fair hearing, you must do so no later than 120 calendar days of getting our letter that says we will not pay for a service.

The Medicaid Hearing Unit is not part of Simply. This office looks at appeals from Florida Medicaid members. If you contact the Medicaid Hearing Unit, we will give them facts about your case. This includes the details you have given us.

How do I contact the state for a fair hearing?

You can contact the Medicaid Hearing Unit at any time during the Simply appeals process. They are at:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
877-254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

You have the right to ask to get benefits during your hearing. Call Member Services toll-free at **877-440-3738** (TTY **711**). If the Medicaid Hearing Unit agrees with Simply, you may have to pay for services you got during the appeal.

Member Dissatisfaction and Grievances

Members who wish to file a grievance through their provider should obtain a grievance form from the Simply website. Once completed, the member or provider can forward the grievance form with any supporting documentation to the attention of our Grievance Unit.

Dissatisfaction Process
We will make every effort to resolve each member dissatisfaction before it becomes a grievance. We encourage members to voice even minor concerns early by contacting their case manager. The vast majority of concerns are resolved at the time of initial contact.

Whether received by telephone or in writing, all member concerns are immediately logged into the Simply Management Information System. If the member's concern cannot be resolved by the close of the next business day, the concern becomes a formal grievance. We will send a letter acknowledging receipt of the request within five business days.

A Member Services representative or case manager logs all dissatisfactions, both oral and written, and tries to resolve the complaint immediately. If the dissatisfaction cannot be resolved at the time of the call, it is forwarded to the Grievances and Appeals team for resolution as a grievance. The Grievance and Appeals team works with the appropriate department within Simply for investigation and review. Member Services uses the language line for assistance, as needed, with interpretive services.

Complaint and grievance procedures are provided to members and providers in alternative formats as needed. This includes audio, large print, Braille, and Spanish. TDD/TTY lines and sign language interpreters are also available. If a member needs help completing a grievance/appeal form, assistance will be provided by telephone, or a member advocate representative will contact the member to provide the requested assistance and may fill out the form for the member. In addition, grievance/appeal forms are available at providers' offices. These assistance services are available at all steps of the grievance and appeal process.

Other Dissatisfactions Handled by Simply
Member dissatisfactions pertaining to receipt of vision services are referred to the respective subcontractor. The subcontractor for these services must report all member dissatisfactions, including the type of complaint and resolution status, to us on a monthly basis. We incorporate this information into the grievance/appeal database for monitoring and trending. If the member calls back and is not satisfied with the response from the subcontractor's Member Services department, a Simply Member Services representative will try to conduct a three-way conference call with the subcontractor and the member to resolve the issue immediately. Member Services may also refer the issue to our Grievances and Appeals department for further review or assistance.

If a vendor receives a complaint from a member related to nonemergent transportation, the vendor will attempt to resolve the complaint. If they are unable to resolve the complaint within 24 hours, the vendor will notify the Grievances and Appeals department, and a grievance coordinator will contact the member to provide assistance.

Grievance Process

A **grievance** is when a member is unhappy about something besides their health benefits. A grievance could be about a doctor's behavior or about information the member should have received but did not.

Possible subjects for grievances include but are not limited to the quality of care, the quality of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member's rights.

Members may file a formal grievance either verbally or in writing at any time after the date of service or occurrence. We can help members write grievances as necessary. All grievances will be acknowledged within five business days. All grievances except clinically related issues are investigated by Grievance department staff with the cooperation of other departments directly involved with the member's concerns. Members may file a grievance by contacting:

- Simply Healthcare Plans, Inc.
  Grievance Coordinator
  P.O. Box 62429
  Virginia Beach, VA 23466-1599
- Office hours: 8 a.m. to 7 p.m.
- Phone: **877-440-3738** (TTY **711**)
- Email us at flmedicaidgrievances@anthem.com
- Fax us at: **866-216-3482**

Resolution of a member's grievance must be completed within 90 days of receipt of the grievance. If the review process takes longer than 90 days, we will send a follow-up letter to the member explaining the status of their case. If an extension is needed, we will send a letter to the member explaining the status of the case and the need for an extension. We will also send the member a resolution letter discussing our decision and the member's right to file a grievance.

The time frame for a grievance may be extended up to 14 calendar days if:

- The member asks for an extension.
- Simply finds additional information is needed, and the delay is in the member's interest. If you disagree with the extension, you can request a grievance.

If the time frame of the grievance is extended other than at the member's request, Simply will call the member on the same day and notify the member in writing within two calendar days of when the ruling is made. If a member has a special need, Simply will give additional help to file the grievance.

If a grievance involves a quality-of-care concern, all providers, agents, and employees of Simply can complete a plan inquiry form and forward it to the Quality Management department for confidential review.

Provider Complaint System

Our provider complaint system allows you to dispute Simply policies, procedures, or any aspect of our administrative functions, including proposed actions. You have 45 calendar days from the date of the occurrence to file a written complaint regarding the dispute. Complaints will be resolved fairly – consistent with health plan policies and covered benefits.

Process for Filing and Submitting a Formal Complaint
You can file a written formal complaint with us via the provider website, email, fax, or mail. Any supporting documentation should accompany the grievance. For assistance with filing a complaint, call Provider Services at **877-440-3738**.

We will:

- Allow 45 days for providers to file a written complaint.
- Notify the provider (verbally or in writing) within three business days of receipt that we have received the complaint and include an expected date of resolution.
- Document why a complaint is unresolved after 30 calendar days of receipt and provide written notice of the status to the provider every 30 calendar days thereafter.

- Resolve all complaints within 90 calendar days of receipt and provide written notice of the disposition as well as the basis of the resolution within three business days of the resolution.

Simply keeps all provider complaints confidential to the extent permitted under applicable law. We will not penalize a provider for filing a complaint.

Provider Complaint Review
Upon receipt of a complaint with supporting documentation, we will thoroughly investigate the complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Simply written policies and procedures. The account executive/manager or director is responsible for resolution of unresolved issues. We will communicate resolution of the issue in writing.

Provider Non-Claim Appeals
Administrative Appeals vs. Medical Necessity Appeals Both administrative and medical necessity appeals must be received within 45 calendar days of the date on the denial letter.

Administrative Appeals
An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of prior authorization or failure by the provider to submit clinical information when requested.

Appeals for administrative denials must address the reason for the denial (i.e., why prior authorization was not obtained or why clinical information was not submitted).
If Simply overturns its administrative decision, the case is reviewed for medical necessity and, if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

Medical Necessity Appeals
A medical necessity appeal is the request for a review of an adverse decision. An appeal encompasses requests to review adverse decisions of care denied before services are rendered (pre-service, with the members written consent) and care denied after services are rendered (post service), such as medical necessity decisions, benefit determination related to coverage, rescission of coverage or the provision of care or service. Simply offers a medical necessity appeal process that allows the providers the opportunity to request and participate in the re-evaluation of adverse actions. The providers will be given the opportunity to submit written comments, medical records, documents, or any other information relating to the appeal. Simply will investigate each appeal request, gathering all relevant facts for the case before making a decision.

How to Submit a Medical Necessity Appeals.
Simply encourages electronic appeals submission; however, providers have the option to submit paper appeals.

Preferred method to submit an appeal digitally via Availity Essentials:
- Request an appeal using Interactive Care Reviewer (ICR), our digital authorization application accessed through Availity for any eligible denied authorization affiliated with your tax id/organization at http://Availity.com:
    - To request an appeal through ICR, you need to have the Authorization Referral Request role assignment on Availity. Your organization's Availity administrator can give you access to this role.
- You can upload supporting documentation through the authorization application and will receive acknowledgement of your submission.

- To be eligible the case must be in a denied status. You can also request a clinical appeal through ICR for cases submitted by phone and fax.
- Verbally: Call Provider Services at **877-440-3738**
- Written: Mail all required documentation:
    - Appeal letters and other related clinical information should be sent to:
      Centralized Appeals Processing
      Simply Healthcare
      P.O. Box 61599
      Virginia Beach, VA 23466-1599

Claims Payment Inquiries or Appeals

Our Provider Experience program helps you with claims payment and issue resolution. Just call **877-440-3738** and select the Claims prompt.

We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

For members who reside in a residential facility, there are requirements for patient responsibility. Residential facilities are nursing homes, adult family care homes and assisted living facilities. Patient responsibility is calculated by the Department of Children and Families. In accordance with *Title 42, Section 435.726*, *Code of Federal Regulations & Section 2404* of the *Affordable Care Act*, patient liability will be withheld from billed charges per the *Medicaid Provider Reimbursement Handbook* guidelines.

Claims Correspondence versus Payment Appeal

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue. The following table also provides guidance on issues considered claim correspondence and should not go through the payment appeal process.

Type of Issue	What Do I Need to Do?
Rejected claim(s)	Work with your EDI vendor or contact Availity Client services at **800-282-4548** if you submitted a claim but was not processed.
***EOP* requests for supporting documentation (itemized bills and invoices)**	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: Simply Healthcare Plans, Inc. Florida Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
***EOP* requests for medical records**	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Simply Healthcare Plans, Inc. Florida Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Type of Issue	What Do I Need to Do?
Need to submit a corrected claim due to errors or changes on original submission	Submit a *Claim Correspondence Form* and your corrected claim to: Simply Healthcare Plans, Inc. Florida Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: Simply Healthcare Plans, Inc. Florida Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

A claim payment appeal (dispute) is any dispute between you and Simply for reason(s) including:

- Contractual payment issues.
- Inappropriate or unapproved referrals initiated by providers.
- Retrospective review.
- Disagreements over reduced or zero-paid claims.
- Authorization issues.
- Timely filing issues.
- Other health insurance denial issues.
- Claim code-editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.

You will **not** be penalized for filing a payment dispute. No action is required by the member. Our procedure is designed to give you access to a timely payment appeal process. We have a two-level appeal process for providers to dispute claim payment. If you are dissatisfied with the resolution of a first-level appeal, we give you the option to file a second-level appeal.

For claims payment issues related to denial based on medical necessity, we contract with physicians who are not network providers to resolve claims appeals that remain unresolved subsequent to first-level determination.

We will abide by the determination of the physician resolving the dispute and expect you to do the same. We will ensure the physician resolving the dispute will hold the same specialty or a related specialty as the appealing provider.

If you disagree with a previously processed claim or adjustment, you may submit a verbal or written request for reconsideration to us. Due to the nature of appeals, some cannot be accepted verbally and therefore must be submitted in writing. The following table provides guidance for determining the appropriate submission method:

Issue type	Written or verbal request allowed?
Denied for timely filing	• If we made an error per your contract: verbal allowed • If you have paper proof: written

Issue type	Written or verbal request allowed?
Denied for no authorization	• If you know an authorization was provided and we made an error: verbal allowed • If you have paper proof: written
Retro-authorization issue	• If requesting retro-review: written
Denied for needing additional medical records *Note: Denials issued for this reason are considered non-clean claims and will not be logged as appeals. These will be treated as inquiries/correspondence.*	• If records have not been received previous to call: written • If records were sent previously and you know they were received and on file: verbal
You feel you were not paid according to your contract, such as at appropriate DRG or per diem rate, fee schedule, Service Case Agreement, or appropriate bed type, etc.	Verbal
The member doesn't have OHI, but claim denied for OHI	Verbal
Claim code editing denial	Written
Denied as duplicate	Verbal
Claim denied related to provider data issue	Verbal
Retro-eligibility issue	Verbal
Experimental/investigational procedure denial	Written
Claims data entry error; data elements on the claim on file do not match the claim you submitted	Verbal
Second-level appeal	Written (verbal not accepted)

If after reviewing this table you determine a verbal appeal is allowed, you can call the PSU at **877-440-3738**. If the appeal must be submitted in writing or if you wish to use the written process instead of the verbal process, the appeal should be submitted to:

Simply Healthcare Plans, Inc.
Payment Appeals
P.O. Box 61599
Virginia Beach, VA 23466-1599

Written appeals with supporting documentation can also be submitted via the payment appeal tool on our provider website. When inquiring on the status of a claim, if a claim is considered appealable due to no or partial payment, a dispute selection box will display. Once this box is clicked, a Web form will display for you to complete and submit. If all required fields are completed, you will receive immediate acknowledgement of your submission.

Online (for reconsiderations and claim payment appeals): Use the secure provider Availity Appeal application at http://Availity.com. Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission.

Locate the claim you want to dispute on Availity Essentials using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard, add the documentation and submit.

For Appeals, your Availity Essentials user account will need the Claim Status role. To send attachments from Claim Status, you'll need the Medical Attachments role.

Simply must receive the payment appeal for reconsideration, whether verbal or written, within 90 days of the *EOP* paid date or recoupment date.

When submitting the appeal verbally or in writing you need to provide:

- A listing of disputed claims.
- A detailed explanation of the reason for the appeal.
- Supporting statements for verbal appeals and supporting documentation for written.

Written appeals should also include a copy of the *EOP* and an *Appeal Request Form*.

Verbal appeals received by the PSU are logged into the appeal database. Written payment appeals are received in our Document Management Department (DMD) and are date-stamped upon receipt. The DMD scans the appeal into our document management system (Macess), which stamps the image with the received date and the scan date. Once the dispute has been scanned, it is logged into the appeal database by the Intake team within the DMD.

Once the appeal is logged, it is routed in the database to the appropriate appeal unit. The appeal associates work appeals by demand drawing items based on first-in, first-out criteria for routing appeals. The appeal associate will:

- Review the appeal and determine the next steps needed for the payment appeal.
- Make a final determination if able based on the issue or will route to the appropriate functional area(s) for review and determination.
- Ensure a determination is made within 60 calendar days of receipt of the payment appeal.
- Contact you via your preferred method of communication (phone, fax, email or letter) and provide the payment information, if overturned or further appeal rights if upheld or partially upheld. Your preferred method of communication is determined from the PSU agent requesting this information during your call or your selection on the *Appeal Request Form*. If no preference is provided, a letter will be mailed to you.

If your claim(s) remains denied, partially paid or you continue to disagree, you may file a second-level appeal in writing. Second-level verbal appeals will not be accepted. The second-level appeal must be received by us within 30 calendar days from the date of the first-level decision/resolution letter. Second-level appeals received after this will be upheld for untimely filing and will not be considered for further payment. You must submit a written second-level dispute to the centralized address for disputes. A more senior appeal associate, or one who did not complete the first-level review, will conduct the second-level review. If additional information is submitted to support payment, the denial is overturned. Otherwise, the appeal associate conducts the review as per the steps in the first-level process.

Once the dispute is reviewed for the second level, the appeal associate will notify you of the decision via your preferred method of communication within 30 calendar days of receipt of the second-level payment appeal.

A licensed/registered nurse will review payment appeals received with supporting clinical documentation when medical necessity review is required. We will apply established clinical criteria to the payment appeal. After review, we will either approve the payment dispute or forward it to the medical director for further review and resolution.

If you are dissatisfied with the Level II payment dispute resolution, you may appeal our decision to Capitol Bridge, the AHCA vendor for provider disputes.

Application forms and instructions on how to file claims are available from Capitol Bridge directly. For information updates, contact Capitol Bridge at FLCDR@capitolbridge.com or call **800-889-0549** and ask for the Florida Appeals Process department.

Claims Overpayment Recovery Procedure
Simply Payment Integrity Division reviews claims for accuracy and requests refunds if claims are overpaid or paid in error. Some common reasons for overpayments are*, but not limited to:*

- Paid wrong provider/Member
- Coordination of Benefits
- Allowance overpayments
- Late credits
- Billed in error
- Duplicate
- Non-covered services
- Claims editing
- Terminated Members
- Total charge overpaid
- Paid wrong Member/ provider number

Overpayments may be identified by two entities — either Simply/our contracted vendors or by the providers.

Identified Overpayment (aka "Solicited")
Once an overpayment has been identified by Simply, Simply will notify the provider of the overpayment. The overpayment notification letter will include instructions on how to refund the overpayment. When refunding on a claim overpayment that Simply has requested, use the payment coupon included on the request letter and the following information with the check:

- The payment coupon
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the refund request letter

As indicated in the Simply refund request letter, provider overpayment refunds not received and applied within the timeframe indicated will result in claim recoupment from any claim the provider submits to Simply.

Providers wishing to submit an overpayment dispute for a solicitated overpayment recoupment request, can submit their request via Availity Essentials, by mail or fax.

The mailing address and fax number are:
Cost Containment — Disputes
PO Box 62427
Virginia Beach, VA 23466-2437
Fax: **866-920-1874**

The processing time once these documents are received is 30 days.

Providers submitting a refund check, should mail the refund to the address below and include a copy of the overpayment letter received, a list of claims are being refunded and the refund amount to be applied to each claim to:

Cost Containment
PO Box 933657
Atlanta, GA 31193-3657

Provider Self-Identified Overpayments (aka "voluntary" or "unsolicited")
To ensure compliance with *42 CFR 438.608(d)(2)*, Simply outlines below our documented mechanism for a Network Provider to report to the Contractor when it has received an overpayment, return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and notify the Contractor in writing of the reason for the overpayment.

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at provider.simplyhealthcareplans.com. The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. The provider can also complete a *Recoupment Notification Form*, which gives Simply the authorization to adjust claims and create claim offsets. This form can also be found on the provider website at provider.simplyhealthcareplans.com.

If a *Refund Notification Form* is not available, the provider can submit the refund check with a letter. The letter should include the following:

- Provider name/contact
- Contact number
- Provider ID
- Provider Tax ID
- Subscriber ID
- Member name
- Member account number
- Date of Service
- Total billed charges
- Total check amount
- Claim number(s)
- Reason for refund or check return:
    - Received an *Overpayment Notification Letter*
    - Contract rate change
    - Duplicate payment
    - Incorrect member
    - Incorrect provider
    - Negative balance
    - Other Health Insurance (OHI)/third-party liability (TPL)
    - Payment error
    - Billed in error/adjusted charge
    - Or other reason

All provider self-identified overpayment requests must be submitted in writing via US mail, fax, or web submission.

Submission options:

USPS Mail:	Cost Containment — Recoupments P.O. Box 62427 Virginia Beach, VA 23466
Fax:	**866-920-1874**

Web submission:	Availity Essentials: http://Availity.com

All requests should include the following information:

- Name of Provider
- Tax ID
- NPI
- Member's full name
- Member's ID
- List of claims
- Reason for the recoupment
- Amount of the recoupment
- Include any supporting documentation to validate the reason for the recoupment.
- Signature authorizing the recoupment.

Provider Self-Identified overpayment request turnaround time: Within 30 business days of receipt.
**Incomplete requests will cause a delay in processing or the closure of the request with no further action.*

Changes addressing the topic of overpayments have taken place with the passage of the *Patient Protection and Affordable Care Act* (*PPACA*), commonly known as the *Healthcare Reform Act*. The provision links the retention of overpayments to false claim liability.

The language of *42 U.S.C.A. § 1320a-7k* makes explicit that overpayments must now be reported and returned to states or respective MCOs (Managed Care Organizations) within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the *False Claims Act* including treble damages. In order to avoid such liability, healthcare providers and other entities receiving reimbursement under Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the *PPACA*.

Provision *42 U.S.C.A. § 1320a-7k*, entitled *Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments*, clarifies the uncertainty left by the 2009 *Fraud Enforcement and Recovery Act*. This provision of the *Healthcare Reform Act* applies to providers of services, suppliers, and Medicaid MCOs.

13 RISK MANAGEMENT

Risk management is defined as the identification, investigation, analysis and evaluation of risks and the selection of the most advantageous method of correcting, reducing, or eliminating identifiable risks.

The Risk Management program at Simply is intended to:

- Protect and conserve the human and financial assets, public image, and reputation of the provider of care and/or the organization from the consequences of risks associated with members, visitors, and employees at the lowest reasonable cost.
- Minimize the incidents of legal claims against the provider of care and/or organization.
- Enhance the quality of care provided to members.
- Control the cost of losses.
- Maintain patient satisfaction with the provider of care and the organization.

The scope of our Risk Management program is organization wide. Each member of the medical care team has an equally important role to play in minimizing the occurrence of incidents. All care providers, agents and Simply employees have the affirmative duty to report adverse or untoward incidents (potential or actual) on an incident report and to send the report to specific personnel for necessary follow-up. The risk manager's activities will contribute to the quality of care and a safer environment for members and employees as well as reduce the cost of risk to the provider and the organization.

These activities are categorized as those directed toward loss prevention (preloss) and those for loss reduction (postloss).

The primary goal of preloss activity is to correct, reduce, modify, or eliminate all identifiable risk situations, which could result in claims and litigation for injury or loss. This can be accomplished by:

- Providing ongoing education and training programs in risk management and risk prevention.
- Participating in safety, utilization review, quality assessment and improvement activities.
- Interfacing with the medical staff to ensure communication and cooperation in risk management.
- Exchanging information with professional organizations, peers and other resources to improve and update the program.
- Analyzing member grievances that relate to member care and the quality of medical services for trends and patterns.

The primary goal of postloss activity is the selection of the most advantageous methods of correcting identifiable risks and claim control. This can be accomplished through an effective and efficient incident reporting system.

All Simply employees will be given education on the Internal Incident Reporting System, which outlines incident -reporting responsibilities and includes the definition of adverse or untoward incidents, access to the incident report form, appropriate routing, and the required time frame for reporting incidents to the risk manager.

Your input and participation in the quality management process further emphasizes the identification of potential risks in the clinical aspects of member care.

Internal Incident Reporting System

The Internal Incident Reporting System establishes the policy and procedure for reporting adverse or untoward incidents that occur.

Definitions

Adverse incident — an injury of an enrollee occurring during the delivery of Managed Care Plan covered services that:

- Is associated in whole or in part with service provision rather than the condition for which such service provision occurred.
- Is not consistent with or expected to be a consequence of service provision.
- Occurs as a result of a service provision to which the patient has not given his informed consent.
- Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

Injury — any of the following outcomes when caused by an adverse incident:

- Death
- Fetal death
- Brain damage

- Spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones
- Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
- Any condition requiring surgical intervention to correct or control
- Any condition requiring definitive or specialized medical or dental attention which is not consistent with the routine management of the patient's case or patient's preexisting physical or dental condition
- Any condition that extends the patient's length of stay
- Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility

Critical incident — events that negatively affect the health, safety, or welfare of a Long Term Care (LTC) Plan enrollee, including the following:

- Altercations requiring medical intervention
- Enrollee death that is otherwise unexpected
- Enrollee death by homicide
- Enrollee death by suicide
- Enrollee death by abuse, neglect, or exploitation
- Enrollee brain damage
- Enrollee spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
- Any condition requiring surgical intervention to correct or control
- Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
- Any condition that extends the patient's length of stay
- Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility
- Suspected abuse, neglect or exploitation
- Injury or major illness as a result of care provider
- Sexual battery
- Medication errors
- Suicide attempts
- Elopement

All Plan contracted providers are also required to report suspected unlicensed Assisted Living Facilities (ALF) and Adult Family Care Homes (AFCH) (408.812, F.S.)

All participating and direct service providers, including home- and community-based services (HCBS) providers, are required to report adverse or critical incidents to Simply within 24 hours of discovery. Simply must ensure all participating and direct service providers are required to report adverse incidents to the Agency immediately, but no more than 24 hours of the incident. Reporting will include information on the enrollee's identity and a description of the incident and outcomes, including current status of the enrollee.

Upon onboarding, participating and direct service providers will be educated on the requirements for reporting critical incidents to the Plan. Providers will also receive training on how to identify and report incidents of suspected human trafficking. Provider training is posted on the Simply website and in the provider manual.

Participating and direct service providers are required to report suspected abuse, neglect, and exploitation of vulnerable adults under 415.1034, F.S., to the Abuse Hotline at **800-96ABUSE** (**800-962-2873**).

Simply will report suspected adult abuse, neglect, and exploitation of enrollees immediately, in accordance with *Chapter 415, F.S.* Suspected cases of abuse, neglect and/or exploitation must be reported to the state's Adult Protective Services unit. The Florida Adult Protective Services has the responsibility for investigating allegations of abuse, neglect and exploitation of elders and individuals with disabilities.

Procedural Responsibilities

- The provider staff member involved in observing or first discovering the unusual incident or a Simply staff member who becomes aware of an incident is responsible for initiating the incident report within 24 hours of discovery. Reports will be fully completed on the incident report form and will provide a clear, concise, objective description of the incident. The director of the department involved in observing the risk situation will assist in the completion of the form if necessary.
- Incident forms will be logged and date-stamped.
- Simply associates will refer quality of care and quality of service issues to the Quality Management (QM) department, and it will solicit information from other departments and/or providers.
- The National Customer Care department associate is responsible for initiating incident reports for member grievances that relate to an adverse or untoward incident.
- The QM committee will review all pertinent safety-related reports.
- The QM committee, medical advisory committee and/or peer review committee will review pertinent member-related reports.
- Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee's case file, that is designated as confidential. Such file shall be made available to the AHCA upon request.
- The only copy of a member incident report will be kept in the office of the risk manager; reports will not be photocopied or carbon copied. Employees, providers, and agents are prohibited from placing copies of an incident report in the medical record. Employees, providers, and agents are prohibited from making a notation in the medical record referencing the filing of an incident report.

Incident Report Review and Analysis

- The risk manager will review all incident reports and analyze them for trends and patterns. This includes the frequency, cause, and severity of incidents by location, provider and type of incident.
- The risk manager will have free access to all health maintenance organization or provider medical records.
- The incident reports will be used to develop categories of incidents that identify problems.
- Once problems become evident, the risk manager will make recommendations for corrective actions such as procedural revisions.
- Should definitive injuries occur, cases will be categorized using the ICD-10CM coding classification.
- An incident report is an official record of incident and is privileged and confidential in all regards. No copies will be made of any incident report for any reason other than those situations authorized by applicable law.

14 CLAIMS AND REIMBURSEMENT PROCEDURES

Simply Website and Provider Inquiry Line

We know you need accurate, up-to-date information to provide the best service to members. You can access authorization status 24 hours a day, 365 days a year via:

- The Simply provider website (provider.simplyhealthcareplans.com)
- Availity Essentials (http://Availity.com)
- The toll-free Provider Inquiry Line (**877-440-3738**)

The Simply provider website provides a host of online resources, featuring our online provider inquiry tool for authorization status. Detailed instructions for use of the online provider inquiry tool can be found on our website.

Our toll-free Provider Inquiry Line is available to help you check member status, claim status and authorization status. This option also offers the ability to be transferred to the appropriate department for other needs such as requesting new authorizations, checking on status, seeking advice in case management, and contacting your account representative.

Claim Timely Filing

Paper and electronic claims must be filed so they are received within:

- Six months from the date of service for participating providers.
- 365 days from the date of service for nonparticipating providers.

Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/provider services.

There are exceptions to the timely filing requirements. They include:

- **Cases of coordination of benefits/subrogation** — For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the third party's resolution of the claim.
- **Cases where a member has retroactive eligibility** — In situations of enrollment in Simply with a retroactive eligibility date, the time frames for filing a claim will begin on the date we receive notification from the enrollment broker of the member's eligibility/enrollment.

We will deny claims submitted after the filing deadline.

Documentation of Timely Claim Receipt

The following information will be considered proof that a claim was received timely. If the claim is submitted:

- **By U.S. mail:** First-class, return receipt requested or by overnight delivery service; you must provide a copy of the claim log that identifies each claim included in the submission.
- **Electronically:** You must provide the receipt date from the response reports.
- **By fax:** You must provide proof of facsimile transmission.

The claims log you maintain must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Patient name
- Date(s) of service/occurrence

- Name of carrier
- Designated address
- Total charge
- Delivery method

Good Cause
If a claim or claim appeal includes an explanation for the delay or other evidence that establishes the reason, we will determine good cause based primarily on that statement or evidence and/or if the evidence leads to doubt about the validity of the statement. We will contact you for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a provider or supplier claim filing delay was due to:

- Administrative error: incorrect or incomplete information furnished by official sources (for example, carrier, intermediary, CMS) to the provider or supplier.
- Incorrect information furnished by the member to the provider or supplier resulting in erroneous filing with another care management organization or with the state.
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties, despite reasonable efforts by the provider/supplier to secure such documentation or evidence.
- Unusual, unavoidable, or other circumstances beyond the service provider's control, which demonstrate the provider or supplier could not reasonably be expected to have been aware of the need to file timely.
- Destruction or other damage of the provider's or supplier's records unless such destruction or other damage was caused by the provider's or supplier's willful act of negligence.

Claims Submission

Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit http://Availity.com > Products > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway).

EDI Response Reports
Claims submitted electronically will return response reports that may contain rejections. If using a clearinghouse or billing vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports, contact your clearinghouse or billing vendor or Availity at **800-AVAILITY (800-282-4548)**.

Availity EDI Payer ID:
SMPLY

Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to http://Availity.com
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to Availity: http://Availity.com/availity/web/public.elegant.login
- Select **My Providers**
- Select **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Contact Availity
Contact Availity Client Services with any questions at **800-AVAILITY (282-4548)**.

For Availity training and additional resources, please visit our website under Provider Resources.

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (enrollsafe.payeehub.org) to register and manage EFT account changes.

Providers who are registered to receive EFT payments will receive an 835 within 3 days after the EFT payment date once the claim is adjudicated.

EDI Submission for Corrected Claims
For corrected electronic claims:

- Use frequency type (7) — Replacement of Prior Claim
- Submit original claim number for the corrected claim

EDI segments required:

- Loop 2300 - CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

Clean Claims Payment
A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted by the provider in a timely manner.
- Is accurate.

- Is submitted on a HIPAA-compliant standard claim form, including a *CMS-1500* or *CMS-1450*, or successor forms thereto, or the electronic equivalent of such claim form.
- Is submitted using the approved Assisted Living, Adult Family Care Home, or Adult Day Care Roster Form.
- Requires no further information, adjustment, or alteration by the provider or by a third party to be processed and paid by Simply.

Clean claims are adjudicated within 30 business days of receipt. If Simply does not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

We produce and mail an *EOP* on a biweekly basis, which delineates the status of each claim that has been adjudicated during the previous week. Upon receipt of the requested information from the provider, we must complete processing of the clean claim within 30 business days.

Paper claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims that are determined to be unclean will be returned to the Simply contracted clearinghouse that submitted the claim.

Website Submission

Availity Essentials offers a variety of online functions to help you reduce administrative costs and gain extra time for patient care by eliminating paperwork and phone calls. You will need to sign up to access it. Once signed up, you can log in to a single account and perform numerous administrative tasks for patients covered by Simply or by other payers.

Claims can be submitted digitally through Availity Essentials. For more information about Availity, such as how to register, training opportunities and more, visit **http://Availity.com** or call **800-AVAILITY** (**800-282-4548**).

Paper Claims Submission

Participating and nonparticipating providers also have the option of submitting paper claims. We use optical character reading (OCR) technology as part of our front-end claims processing procedures. OCR technology is coupled with an imaging module to furnish providers with a more responsive claims processing interface. The benefits include:

- Faster turnaround times and adjudication.
- Claims status availability within five days of receipt.
- Immediate image retrieval by Simply staff for claims information, allowing for more timely and accurate response to provider inquiries.

To use OCR technology, claims must be submitted on original red claim forms (not black-and-white or photocopied forms) laser printed or typed (not handwritten) in a large, dark font. Participating providers must submit a properly completed *CMS-1450* or *CMS-1500 (08-05)* form so it is received within six months from the date of service, and nonparticipating providers must submit the same forms so it is received within 365 days from the date of service.

In accordance with the implementation timelines set by CMS and by the National Uniform Claim Committee, we require use of the *CMS-1500 (08-05)* and *CMS-1450* forms to accommodate your NPI.

The *CMS1500 (0805)* or *CMS1450* form must include the following information (HIPAA compliant, where applicable):

- Member ID
- Provider tax ID number

- Member name
- Member date of birth
- ICD-10 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered
- Itemized charges
- Days or units
- Provider name according to contract
- Simply provider number
- NPI of billing provider when applicable
- State Medicaid ID
- Coordination of benefits/other insurance information
- Authorization/preauthorization number
- Any other state-required data

We cannot accept claims with alterations to billing information. Claims that have been altered will be returned with an explanation for the return. We will not accept claims from those providers who submit entirely handwritten claims.

Paper claims must be submitted to the following address:

Simply Healthcare Plans, Inc.
Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

International Classification of Diseases, 10th Revision (ICD-10) Description

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with *HIPAA* requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding.
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

Roster

Assisted living facilities, adult family care homes and adult day health services can submit a Simply-approved roster claim form. The roster claim form must be clean, free of alterations and complete. Alterations include using white-out and crossing out or writing over mistakes. This roster claim form must be faxed to **866-779-3031**.

Encounter Data

We established and maintain a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to us for each member encounter. Encounter data can be submitted through EDI submission methods or on a *CMS-1500*

(08-05) claim form unless we approve other arrangements. Data will be submitted in a timely manner but no later than 180 days from the date of service. The encounter data will include the following:

- Member ID number
- Member name (first and last)
- Member date of birth
- Provider name according to contract
- Simply provider ID
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider tax ID number and state Medicaid ID number

Submit **encounter data** to the following address:

Simply Healthcare Plans, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

Our utilization and quality improvement staff monitors compliance, coordinates with the medical director and reports to the quality management committee on a quarterly basis. We monitor the primary care provider for compliance with utilization reporting. Lack of compliance will result in training and follow-up audits and could result in termination from the network.

Claim Adjudication

All network and non-network provider claims submitted to Simply for payment will be processed in accordance with *F.S. 641.3155* according to *Generally Accepted Claims Coding and Payment Guidelines*. These guidelines are designed to comply with industry standards as defined by CPT-4, ICD-10, and resource-based relative value scale (RBRVS) handbooks.

We use code-auditing software to comply with an ever-widening array of code edits and rules. Additionally, this review increases consistency of payment for providers by ensuring correct coding and billing practices are being followed. A sophisticated auditing logic determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology, and anesthesia codes to process those services according to industry standards. The auditing software is updated periodically to conform to changes in coding standards and to include new procedure and diagnosis codes.

For questions regarding any edits that you receive on your explanation of payment, contact Provider Services at **877-440-3738**.

For appropriate filing information, see *CMS-1500* claim form instructions and *CMS-1450* claim form instructions. Failure to provide any of the required information can result in payment being delayed.

Timely filing of claims from participating providers must occur within six months of the date of service (180 days) and within 365 days for nonparticipating providers. We typically adjudicate claims submitted for payment under Simply coverage within 15 days of submission for clean claims.

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.

Provider Services: 877-440-3738
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