Simply healthcare | CLEAR HEALTH ALLIANCE

Provider Manual

Florida Statewide Medicaid Managed Care Managed Medical Assistance and Florida Healthy Kids

Provider Services: **844-405-4296**

https://provider.simplyhealthcareplans.com | https://provider.clearhealthalliance.com

Copyright November 2025 Simply Healthcare Plans, Inc.

All rights reserved. This publication, or any part thereof, may not be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, storage in an information retrieval system, or otherwise, without the prior written permission of the Provider Communications Department, 5800 Northampton Blvd., Norfolk, VA 23502.

How to apply for participation

If you are interested in applying for participation with Simply Healthcare Plans, Inc. (Simply), we have added functionality to the provider enrollment tool hosted on Availity Essentials to further automate and improve your online enrollment experience.

Digital provider enrollment is currently only available for professional practitioners. Facility and ancillary providers, please submit a letter of interest to the following address:

Attn: Provider Relations
Simply Healthcare Plans, Inc.
5411 Sky Center Drive, Floor 7
Tampa, FL 33607

The tool provides the below features:

- Apply and request a contract to enroll a new group of practitioners
- Monitor submitted applications statuses real-time with a digital dashboard

The system pulls in all your professional and practice details from Council for Affordable Quality Healthcare (CAQH) ProView to populate the information we need to complete the enrollment process — including credentialing, claims, and directory administration. Please ensure your provider information on CAQH is updated and in complete or re-attested status.

The online enrollment application will guide you through the process, and a dashboard will display real-time application status. You'll know where each provider is in the process without having to call or email for a status.

To begin the enrollment process, log onto **Essentials.Availity.com**, select Florida from the state drop-down, then select Payer Spaces > Simply > Applications > Provider Enrollment and Network Management. If your organization is not currently registered for Availity Essentials, the person in your organization designated as the Availity administrator should go to **Availity.com** and select Create Account. For organizations already using Availity, your administrator(s) will automatically be granted access to the provider enrollment tool. Staff using the provider enrollment tool need to be granted the user role Provider Enrollment by an administrator. To find yours, go to My Account Dashboard > My Account > Organization(s) > Administrator Information.

Need assistance with registering for Availity Essentials? Log onto **Availity.com/multi-payer-portal-registration/#get-started**.

TABLE OF CONTENTS

1 INTRODUCTION 7

Welcome 7

Updates and Changes 7

2 OVERVIEW 8

Who Is Simply? 8

Mission 8

Strategy 8

Summary 8

3 QUICK REFERENCE INFORMATION 9

Simply Provider Website 9

Simply Phone Numbers 9

Other Telephone Numbers 9

Provider Experience Program 10

Ongoing Provider Communications 11

4 PRIMARY CARE PHYSICIANS 15

Primary Care Physicians 15

Provider Specialties 15

Primary Care Physician Onsite Availability 16

Provider Termination/Disenrollment Process 16

Member Enrollment 17

Involuntary Disenrollment 17

Newborn Enrollment 18

Members Eligibility Listing 18

Medicaid Eligibility and Enrollment 18

Member ID Cards 18

Americans with Disabilities Act Requirements 19

Medically Necessary Services 19

Continuity of Care: New Members 19

Continuity of Care: Provider Termination 20

5 SIMPLY HEALTHCARE BENEFITS AND COPAYMENTS 21

Simply Covered Services 21

Enhanced Benefits 38

Florida Healthy Kids Expanded Benefits 46

Taking Care of Baby and Me® Program 46

Neonatal Intensive Care Unit (NICU) Care Management 47

Community Partnerships to Improve Outcomes (CPIO) Program 48

Quality Enhancement Program 48
Well-Child Visits/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Statewide Medicaid Managed Care Managed Medical Assistance, and MediKids Members 49
Well-Child Visits Reminder Program 50
Blood Lead Testing Requirements 50
Vaccines for Children for Medicaid Recipients 51
Family Planning Services 51
Healthy Rewards — Healthy Behaviors Rewards Program 51
Audiology Services 52
Outpatient Laboratory and Radiology Services 52
Pharmacy Services 54
Behavioral Health Services 56
Self-Referral Services 58
Member Rights and Responsibilities 58
First Line of Defense Against Fraud 59
Investigation Process 61
About Prepayment Review 62
Acting on Investigative Findings 63
HIPAA 64
Legally Restricted Services 64
6 MEMBER MANAGEMENT SUPPORT 65
Welcome Call 65
Appointment Scheduling 65
24/7 NurseLine 65
24/7 Pharmacy Member Services 65
Interpreter Services 65
Health Promotion 65
Case Management 66
HIV/AIDS Specialty Care Case Management 67
Condition Care Program 67
Health Management: Healthy Families Program 69
Enrollee Advisory Committee 69
Women, Infants, and Children Program 70
Pregnancy-Related Requirements 70
Healthy Start Program 73
Local Health Department 73
7 PROVIDER RESPONSIBILITIES 74

Medical Home 74
Providers' Bill of Rights 74
Provider and Facility Digital Guidelines 75
Submitting provider demographic data requests and roster submissions through Roster Automation 80
Responsibilities of the PCP 80
Role of the PCP 84
Physician Extenders 85
Home Health Agencies 85
Background Checks 85
Abuse, Neglect, and Exploitation 85
Identifying Victims of Human Trafficking 86
Access and Availability 87
Member Missed Appointments 88
Noncompliant Simply Members 88
PCP Transfers 89
Covering Physicians 89
Specialist as a PCP 89
Specialty Referrals 89
Second Opinions 90
Specialty Care Providers 91
Role and Responsibility of the Specialty Care Provider 92
Specialty Care Providers Access and Availability 93
Open-Access Specialist Providers 93
Professional and Respectful Communication Standards 93
Restrictions on AI use in Performing a Health Plan Function 94
Culturally and Linguistically Appropriate Services 94
Marketing 95
Member Records 96
Patient Visit Data 99
Misrouted Protected Health Information 100
Advance Directives 100
Telemedicine 101
8 MEDICAL MANAGEMENT 102
Medical Review Criteria 102
Precertification/Notification Process 102
Utilization Management Decision Making 103
Access to UM Staff 103

Preventive Care Guidelines 103
Clinical Practice Guidelines 104
Hospital and Elective Admission Management 106
Nonemergent Outpatient and Ancillary Services: Precertification and Notification Requirements 107
Inpatient Reviews 107
Discharge Planning 108
Confidentiality of Information 108
Emergency Services 109
Urgent Care 110
9 QUALITY MANAGEMENT 111
Quality Management Program 111
Quality Management Committee 113
Medical Advisory Committee (MAC) 113
Provider Orientation and Education 115
Medical Record Documentation Review Standards 115
Infection Prevention 163
Risk Management 164
Credentialing 167
Provider Temporary Enrollment 186
Quality Measurement Standards for Providers and Requirements for Exchange of Data 187
10 MEMBER APPEAL AND GRIEVANCE PROCEDURES 190
Overview 190
Complaints and Grievances 190
Medical Appeals 191
11 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES 194
Electronic Submission 194
Useful EDI Documentation 195
Paper Claims Submission 195
Encounter Data 196
Medical Attachments 196
Claims Adjudication 197
International Classification of Diseases, 10th Revision (ICD-10) Description 197
Clean Claims Payment 198
Claims Status 198
Provider Reimbursement 198
PCP Reimbursement 199
Outlier Reimbursement - Audit and Review Process 203

Respiratory Services 206
Tech Support Charges 206
Undocumented or Unsupported Charges 207
Claim Payment Disputes 212
Claim Inquiries 214
Claim Correspondence 215
Medical Necessity Appeals 217
Coordination of Benefits 217
Billing Members 217
Accessing Claim Status, Member Eligibility, and Authorization Determinations 218
APPENDIX A: Forms 219

1 INTRODUCTION

Welcome

Simply Healthcare Plans, Inc. (Simply) would like to welcome you to the Florida Statewide Medicaid Managed Care and Florida Healthy Kids 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 hospitals, physicians, and other providers play a pivotal role in managed care, and we can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. All network providers are contracted with Simply through a Participating Provider Agreement.

Note: This manual provides standards for services to Simply members enrolled in the Medicaid Managed Care, Medicaid Specialty Plan, and Florida Healthy Kids programs. If a section of the manual applies only to a specific program, that program will be indicated. If there is no such indication, the information is applicable to all programs.

This provider manual does not apply to members of the Medicare Advantage or the SMMC Long-Term Care (LTC) program. For more information about providing services to Medicare Advantage members, call **844-405-4297**. For more information about providing services to LTC members, call **877-440-3738**.

The LTC provider manual is posted online at **provider.simplyhealthcareplans.com**.

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 at no cost, call Provider Services at **844-405-4296**, and we'll be happy to send you a copy.

The provider manual, as part of your *Participating 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 shall govern.

In the event of a material change to the provider manual, we will make all reasonable efforts to notify you in advance of the change through web-posted newsletters, email or fax communications, and other mailings. In such cases, the most recently published information should supersede all previous information and be 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 healthcare coverage exclusively to low-income families, children, and pregnant women. We participate in the Florida Healthy Kids, Statewide Medicaid Managed Care (SMMC) Long-Term Care, SMMC Serious Mental Illness (SMI) Specialty Plan, SMMC HIV/AIDS Specialty Plan, and SMMC Managed Medical Assistance programs.

Mission

Together, we are transforming healthcare with trusted and caring solutions.

Strategy

Our strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a primary care physician who will serve as provider, care manager, and coordinator for all medical services.
- Improve the health status and outcomes of members.
- Educate members about their benefits, responsibilities, and the appropriate use of healthcare services.
- Encourage stable, long-term relationships between providers and members.
- Monitor for medically inappropriate use of specialists and emergency rooms.
- Commit to community-based enterprises and community outreach.
- Facilitate the integration of physical healthcare and behavioral health.
- Foster quality improvement mechanisms that actively involve providers in re-engineering healthcare delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.

Summary

The Florida legislature created a program called Statewide Medicaid Managed Care (SMMC). As a result, the Agency for Health Care 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) and specialty 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.

For more information on the LTC program, please refer to our LTC provider manual at **provider.simplyhealthcareplans.com**.

The MMA program was implemented in all Florida regions on 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.

In 1990, the state of Florida created the Florida Healthy Kids Corporation, a nonprofit organization, to administer the Florida Healthy Kids program. Through this program, parents can get affordable healthcare coverage for eligible children ages 5 through 18.

3 QUICK REFERENCE INFORMATION

For precertification/notification, network information, member eligibility, claims information, inquiries, and recommendations you may have about improving our processes and/or managed care program, chat with Simply through Payer Services on **Essentials.Availity.com** or call Provider Services.

Simply Provider Website

Visit our website at **provider.simplyhealthcareplans.com** for the full complement of online provider resources. It features online provider inquiry tools for real-time information about member eligibility, prior authorization requirements, claims status, claims resubmission, and claims disputes. You can submit demographic changes and provider rosters on **Essentials.Availity.com**.

In addition, the website has other resources and materials to help you work with us, including provider forms, the MMA and *FHK Preferred Drug Lists*, a list of drugs requiring prior authorization, provider manuals, referral directories, electronic remittance advice and electronic funds transfer information, updates, and clinical practice guidelines.

Access **providernews.simplyhealthcareplans.com** to stay current on all news and announcements related to your practice and patients.

Simply Phone Numbers

Department/Function	Phone Number
Provider Services	**844-405-4296 (phone)** **800-964-3627 (authorizations fax)**
TTY number	**711**
Automated Provider Services line for member eligibility	**844-405-4296**
Electronic Data Interchange (EDI)	Availity Client Services at **800-AVAILITY (800-282-4548)**
Member Services (including the 24/7 NurseLine)	Medicaid: **844-406-2396 (TTY 711)** FHK: **844-405-4298 (TTY 711)** HIV/AIDS Plan: **844-406-2398 (TTY 711)**
Pharmacy Services	**844-405-4296**
Medical Injectable Medication Prior Authorization Fax Retail Prior Authorization Fax	**844-509-9862 (fax)** **877-507-9045**

Other Telephone Numbers

Organization/Program	Phone Number
HIV/AIDS Plan Case Management	**855-459-1566**
iCare (vision)	**855-373-7627**
Carelon Behavioral Health, Inc. (behavioral health services)	**844-280-9633 for HIV/AIDS Plan** **844-375-7215 for MMA** **855-861-2142 for FHK**
20/20 Hearing Care Network, Inc.	**844-575-4327**

Organization/Program	Phone Number
Vaccines for Children (for Simply SMMC MMA only)	**800-483-2543**
Immunization Registry (SHOTS)	**877-888-SHOT (877-888-7468)**
Healthy Start Program	**855-889-1090** **850-999-6200**
Women, Infants, and Children and Nutritional Service	**800-342-3556**
Florida Quitline (smoking cessation)	**877-UCANNOW (877-822-6669)**
Carelon Medical Benefits Management, Inc. (radiology authorization)	**877-202-5276**
CarelonRx, Inc. Pharmacy Help Desk	**833-235-2030**
LabCorp	**800-877-5227**
Elder Abuse Hotline	**800-96-ABUSE (800-962-2873)**
Ride2MD (Non-Emergency Transportation)	**877-671-6671 for HIV/AIDS Plan** **844-628-0388 for MMA** **833-833-2303 for FHK** **844-671-6662 for LTC**
Health Network One (OT, PT, ST)	**888-550-8800** **855-410-0121 (fax)**
Dermatology Network Solutions	**844-222-3535**
Podiatry Network Solutions	**844-222-3939**
American Specialty Health Group Inc. (chiropractic/acupuncture)	**800-972-4226 for MMA, LTC, and FHK**
Integrated Home Care Services	**844-215-4264**

Provider Experience Program

To thank you for the quality of care you give our members, we work to continuously increase service quality for you. Our Provider Experience program, focused on claims payment and issue resolution, does just that!
Call **844-405-4296** with claims payment questions or issues. The Provider Experience program support model connects you with a dedicated resource team to ensure:

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

Our representatives are available Monday to Friday, 8 a.m. to 7 p.m. ET (excluding state holidays). Additional staff is available after-hours for authorization inquiries and requests.

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 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 register and access **Provider Pathways**, a 24/7 educational resource that offers a foundation for doing business with Simply.

Visit the **Digital Solutions 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

The additional information below will help you in your day-to-day interactions with Simply.

Department/Function	Additional Details
Member Eligibility	• Online: **Essentials.Availity.com** (select Patient Registration > Eligibility and Benefits Inquiry) • By phone: Call the automated Provider Services line at **844-405-4296**
Member Enrollment/Disenrollment	Medicaid recipients can enroll in Simply online at **flmedicaidmanagedcare.com** or by calling **877-711-3662** (**TTY 866-467-4970**). Florida Healthy Kids members should contact the Florida Healthy Kids Corporation at **800-821-5437**.
Notification/Precertification	Precertification requests may be submitted: • Online: **Essentials.Availity.com** (select Patient Registration > Authorizations & Referrals) • By phone: **844-405-4296** • By fax: 800-964-3627 The following data is required for complete notification/ precertification: • Member ID • Legible name of referring provider • Legible name of individual referred to provider • National provider identifier and/or tax ID number • Number of visits/services • Date(s) of service • Diagnosis • CPT®/HCPCS codes In addition, clinical information is required for precertification. Authorization forms are available on our provider websites.

Department/Function	Additional Details

Claims Information	• **Availity Electronic claims payer IDs:**
	  ○ Simply = SMPLY
	  ○ HIV/AIDS Plan = CLEAR
	• For EDI assistance, providers may call **Availity Client Services at 800-282-4548**.
	• Submit claims online: **Essentials.Availity.com** (select **Claims & Payment** > **Claims & Encounters**)
	• Check Claim Status Online: **Essentials.Availity.com** (select **Claims & Payment** > **Claim Status**)
	• **Submit paper claims to:**
	Simply Healthcare Plans, Inc.
	Florida Claims
	P.O. Box 61010
	Virginia Beach, VA 23466-1010
	• Timely filing is within six months of the date of service or discharge from an inpatient facility or the date the nonparticipating provider was furnished with the correct name and address of the plan when applicable.
	• For other commercial, non-Medicare insurer crossover claims, timely filing is 90 days after the final determination of the final payer, and is three years for Medicare crossover claims.
	• Simply provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status, and authorization status, which is available through our provider websites.
	• If you're unable to access the internet, you may receive claims, eligibility, and authorization status over the phone by calling our toll-free, automated Provider Services line at **844-405-4296**.

Medical Authorizations Appeal Information	• Providers may submit a medical authorization related appeal within 120 calendar days from the date of an adverse determination. Within three business days of receipt of a complaint, Simply will notify the provider (in writing) that the complaint has been received and the expected date of resolution. They will: • Document why an appeal is unresolved after 30 days of receipt and provide written notice of the status to the provider every 30 days thereafter. • Resolve all appeals within 90 days of receipt. • Provide written notice of the disposition and basis of the resolution to the provider within three business days of resolution. • **The preferred method for providers to submit appeal requests is via the web at Essentials.Availity.com.** To find more details on Availity Essentials and submitting electronic appeals, visit our **Availity Portal Pocket Guide**. • **Providers may also mail appeal requests to:** Simply Healthcare Plans, Inc. Medical Appeals P.O. Box 62429 Virginia Beach, VA 23466-2429

Department/Function	Additional Details
Payment Dispute	• Providers have 90 calendar days from the date of the final determination of the primary payer to file a written complaint for claims issues. Within three business days of receipt of a claim complaint, Simply will notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution. Within thirty (30) days of receipt of a claim dispute, Simply will provide written notice of the status of the dispute to the Agency and provider. In accordance with Section 641.3155 F.S., Simply will resolve all claims complaints within 60 days of receipt and provide written notice of the disposition and basis of the resolution to the provider within three business days of resolution. • Our Provider Experience program also helps you with claims payment and issue resolution. Just call **844-405-4296** and select the Claims prompt. • File a payment dispute digitally: ○ Use Availity Essentials at **Essentials.Availity.com**. Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission. • File a payment dispute to: Simply Healthcare Plans, Inc. Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599
Grievances	**Provider grievances that are not related to claims payment should be submitted in writing to:** Simply Healthcare Plans, Inc. Attn: Member Appeals PO Box 62429 Virginia Beach, VA 23466-2429 Fax: **866-216-3482** • Providers have 45 calendar days from the day of occurrence to file a written grievance. • Document why a complaint is unresolved after 30 days of receipt and provide written notice of the status to the provider every 30 days thereafter. • Resolve all grievances within 90 days of receipt. • Provide written notice of the disposition and basis of the resolution to the provider within three business days of resolution.

Department/Function	Additional Details
Provider Termination Appeals Process	**Provider termination appeals should be submitted in writing to:** Simply Healthcare Plans, Inc. Attn: Provider Appeals 11430 NW 20th Street, Suite 300 Miami, FL 33172 Fax**: 800-964-3627** • Providers have 30 calendar days from the date they receive the termination notice to submit a written appeal.
Case Managers	• Case managers are available from Monday to Friday, 8 a.m. to 7 p.m., Saturday 8 a.m. to 5 p.m. ET. • For urgent issues, assistance is available after normal business hours, on weekends, and on holidays through the Provider Services line at **844-405-4296**. • For the HIV/AIDS Plan case managers, call **855-459-1566**.
Pharmacy Prior Authorization (PA)	• For links to the *Preferred Drug Lists* (*PDLs*), pharmacy PA criteria, and pharmacy PA forms, go to the *Pharmacy* section on our provider websites. • You can initiate PA requests by: ○ Calling the Simply Provider Services line at **844-405-4296** ○ Faxing completed pharmacy PA forms to Simply at **877-577-9045** for retail pharmacy requests or **844-509-9862** for medical injectable requests. ○ Submitting electronic PA requests through **covermymeds.com**.
Specialty Pharmacy	• Specialty prescriptions can be filled at any in-network pharmacy that has access to the drug and can dispense in accordance with the U.S. FDA's approved manufacturer label. • Or prescriptions can be sent to BioPlus Specialty Pharmacy: ○ Call BioPlus Specialty pharmacy at **833-549-2115** ○ Fax BioPlus Specialty pharmacy at **800-269-5493.** Please include a copy of the member's Medicaid ID card
Florida Medicaid Pregnancy Notification Form	The Medicaid Pregnancy Notification Form can be found on our provider website. Please complete the form and submit to the health plan via fax or email. A new digital option is also available on Availity Essentials. • **Form: Notification of Pregnancy (NOP) Coversheet and Form** • **Email:** dl-shp-cm_dm_referrals@simplyhealthcareplans.com • **Fax: 877-577-0117** • **Availity Essentials: Essentials.Availity.com**, select Florida, then select Payer Spaces > Simply > Applications > Notice of Pregnancy **Note:** If you are submitting the form via email, please encrypt the email prior to submission due to inclusion of Protected Health Information (PHI).

4 PRIMARY CARE PHYSICIANS

Primary Care Physicians

The PCP serves as the entry point into the healthcare system for the member. The PCP must be a physician or network provider/subcontractor who provides or arranges for the complete care of their patients, including but not limited to providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, case management, and maintaining continuity of care. The PCP's responsibilities include, at a minimum:

- Managing the medical and healthcare needs of members to ensure all medically necessary services are made available in a timely manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid Fee-for-Service.
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients for services that may be available through Fee-for-Service Medicaid.
- Processing patient referrals within three business days of an office visit to ensure timely care;
- Advising members to schedule appointments for services requiring referrals at least one week after the PCP visit to allow for processing.
- Maintaining a medical record of all services rendered by the PCP and other referral providers.
- Seeing newly enrolled pregnant members within 30 days of enrollment.

The PCP may practice in a solo or group setting or may practice in a clinic (for example, a Federally Qualified Health Center [FQHC] or Rural Health Center [RHC] or outpatient clinic).

Simply encourages enrollees to select a PCP who provides preventive and primary medical care as well as authorization and coordination of all medically necessary specialty services. Members are encouraged to make an appointment with their PCP within 90 calendar days of their effective date of enrollment. For more information on appointment availability standards, see the **Access and Availability** section. FQHCs, RHCs, and County Health Departments may function as a PCP.

Providers must arrange for coverage of services to assigned members:

- 24 hours a day, 7 days a week, in person or by an on-call physician.
- By answering emergency telephone calls from members within 30 minutes.
- By providing a minimum of 20 office hours per week of personal availability as a PCP.

Provider Specialties

Physicians with the following specialties can apply for enrollment with Simply as a PCP:

- Family practitioners
- General practitioners
- General pediatricians
- General internists
- Advanced registered nurses
- Nurse practitioners
- Practitioners certified as specialists in family practice/pediatrics
- FQHCs and RHCs
- Obstetricians/gynecologists (OB/GYNs) (for women when they are pregnant)
- Infectious Disease providers (HIV/AIDS Plan only)

The provider must be enrolled in the Medicaid program at the service location where they wish to practice as a PCP before contracting with Simply. PCPs caring for members from birth through 18 years of age must also be registered in the Vaccines for Children (VFC) program and obtain all vaccines for our eligible members through the VFC program. Please note, Title XXI MediKids members are not eligible for vaccines through the VFC program.

A provider must be a board-certified pediatrician, family practitioner, or physician extender working under the direct supervision of a board-certified practitioner if they wish to practice as a Florida Healthy Kids (FHK) PCP (unless granted an exemption by the Florida Healthy Kids Corporation board of directors).

Our FHK primary care network may also include PCPs who:

1. Have recently completed a residency program in pediatrics or family practice approved by the National Board for Certification of Training Administrators of Graduate Medical Education programs, and
2. Are eligible for but have not yet achieved board certification. If a PCP does not achieve board certification within the first three years of initial credentialing, we will remove that provider from our network and reassign members to a board-certified PCP.

All PCPs in our network must provide all covered immunizations and the Advisory Committee on Immunization Practices (ACIP) recommended immunizations to Simply members and be enrolled in the Florida State Health Online Tracking System (SHOTS), the statewide immunization registry.

Primary Care Physician Onsite Availability

Simply is dedicated to ensuring access to care for our members, and this depends on the accessibility of network providers. Simply network providers are required to abide by the following standards:

- PCPs must offer telephone access to member 24 hours a day, 7 days a week.
- A 24-hour telephone service may be used. The service may be answered by a designee, such as an on-call physician or nurse practitioner with physician backup, an answering service, or a pager system; however, this must be a confidential line for member information and/or questions. An answering machine is **not** acceptable. If an answering service or pager system is used, the call must be returned within 30 minutes.
- The PCP or another physician/advanced registered nurse practitioner must be available to provide medically necessary services.
- Covering physicians are required to follow the referral/precertification guidelines.
- It is **not** acceptable to automatically direct the member to the emergency room when the PCP is not available.

We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

For more information on access and availability standards, see the **Access and Availability** section.

Provider Termination/Disenrollment Process

Providers may cease participation with Simply for either involuntary or voluntary reasons. Involuntary termination occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include illness and/or death. A notice to affected members will be issued immediately upon the health plan becoming aware of the situation.

Providers must give timely notice of voluntary contract termination per the required timeframes in their Simply contracts, but not to exceed 90 calendar days. Should a provider cease participation for a voluntary reason, such as retirement, a written notice to the affected members will be issued no less than 90 calendar days prior to the effective date of the termination and no more than 10 calendar days after receipt or issuance of the termination notice.

If a member is in a preauthorized, ongoing course of treatment with the provider who suddenly ceases participation as a result of death, illness, or Medicaid exclusion, we will notify the member in writing within 10 calendar days from the date we become aware of the provider's network status.

Member Enrollment

Members who meet the state's eligibility requirements for participation in managed care are eligible to join Simply. Members are enrolled without regard to their health status. Members are enrolled for a period of 12 months, contingent upon continued eligibility.

The member may request disenrollment without cause at any time during the 120 days following the date of the member's initial enrollment with Simply or with agency approval. Unless the member loses eligibility or submits an oral or a written disenrollment request to change managed care plans for cause, the member remains enrolled in a health plan for the remainder of the 12-month period.

Simply will ensure all written and oral disenrollment requests are promptly referred to Florida Statewide Medicaid Managed Care (SMMC). When we receive a written request, we will send a letter notification to the member within three business days that advises to call SMMC enrollment and disenrollment services at **877-771-3662** (TTY **866-467-4970**).

For member enrollment for Florida Healthy Kids, call **800-821-KIDS** (**5437**).

Involuntary Disenrollment

Simply may request involuntary disenrollment of a member under the following conditions:

- Member's Medicaid ID card is fraudulently used.
- Falsification of prescriptions by a member.
- Member takes part in disruptive and abusive behavior not related to a member's behavioral health condition.

Action related to a request for involuntary disenrollment conditions must be clearly documented in the member's records and submitted to the local Simply Provider Operations department. The Agency for Health Care Administration (AHCA) will be responsible for reviewing, approving, and processing all requests for disenrollments.

The documentation must include attempts to bring the member into compliance. A member's disruptive and/or abusive behavior resulting in their failure to be in compliance with their treatment plan must be documented prior to submitting a request for involuntary disenrollment to AHCA. The member must have received at least one verbal and one written warning regarding the implications of their actions including involuntary disenrollment.

For any action to be taken, it is mandatory that copies of all supporting documentation from the member's file are submitted with the request.

In addition to the reasons cited in *Rule 59G-8.60 (o), F.A.C.,* if the member is an American Indian or Alaskan Native as defined in *42 CFR 438.14(a)*, that constitutes a cause for disenrollment.

Simply must be notified before transferring a member out of a physician's practice.

Newborn Enrollment

All providers are responsible for reporting member pregnancies to us to initiate the unborn child's Medicaid eligibility process and ensure appropriate case management.

Simply is responsible for all Medicaid-eligible newborns of enrolled members. This includes payment of medically necessary services and well-childcare for the newborn from the date of their birth regardless of the mother's continued enrollment in the plan (unless the newborn is disenrolled).

For all pregnant members we are aware of, we will submit a request to Department of Children and Families (DCF) for the assignment of an inactive Medicaid ID for the unborn child. When the baby is born, we will submit a request to DCF to activate the Medicaid ID to ensure plan enrollment and claims payment. For babies born without a Medicaid ID, we will submit a request to DCF for a presumptive eligible newborn Medicaid determination to obtain a Medicaid ID for the baby.

Members Eligibility Listing

The PCP can review their panel of assigned members online through ***Provider Online Reporting*** located on Availity's Payer Spaces - Log in to Availity Essentials (**Essentials.Availity.com**), select your state from the drop-down menu, select Payer Spaces, and choose your health plan tile. Provider Online Reporting will be in the application tab. To receive a listing of assigned panel members by mail on the first day of each month, the PCP must request the list from their Provider Relations representative. The list will consist of Simply members who have chosen the PCP's office to provide services. If a member calls to change their PCP, the change will be effective the next business day. The PCP should verify that each Simply member receiving treatment in their office is on the membership listing. If a PCP does not receive the listing in a timely manner, they should contact a Provider Relations representative. For questions regarding a member's eligibility, providers can access our provider websites or call the automated Provider Services line at **844-405-4296**.

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)).

Member ID Cards

The ID card identifies the member as a participant in the Simply program. Providers should verify member eligibility and plan enrollment prior to rendering services via the state's Florida Medicaid Management Information System (FMMIS) and/or the Simply provider portal.
The ID card will include the following:

- The member's ID number
- The member's name (first and last names and middle initial)
- The member's enrollment effective date
- Toll-free phone numbers for information and/or authorizations
- Toll-free 24/7 NurseLine information (accessible 24 hours a day, 7 days a week)
- Descriptions of procedures to be followed to obtain emergency or specialty services
- The PCP's name, address, and telephone number
- Pharmacy claims processing information
- A phone number for nonparticipating providers to access billing information

Americans with Disabilities Act Requirements

Simply policies and procedures are designed to promote compliance with the Americans with Disabilities Act of 1990. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access.
- An elevator or accessible ramp into facilities.
- Access to a lavatory that accommodates a wheelchair.
- Access to an examination room that accommodates a wheelchair.
- Handicapped parking space(s) that are clearly marked unless there is street-side parking.
- Provisions to communicate in the language or fashion primarily used by their members.

Medically Necessary Services

Medically necessary health services mean health services that are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- 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 where care can be provided 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 services furnished in a hospital on an inpatient basis, medical necessity means appropriate medical care cannot be effectively given 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.

Continuity of Care: New Members

Simply provides continuation of services until the member’s PCP, or behavioral health provider as applicable, reviews the member’s treatment plan.

We’ll honor any written documentation of prior authorization of ongoing covered services for a period of up to 90 days after the effective date of enrollment or until the member’s PCP (or behavioral health provider, as applicable) reviews the member's treatment plan, whichever comes first. For all members, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, provided the services were prearranged prior to enrollment with Simply:

- Prior existing orders
- Provider appointments (in other words, transportation, dental appointments, surgeries)
- Prescriptions (including prescriptions at nonparticipating pharmacies)
- Prior authorizations
- Treatment plan/plan of care

We would not delay service authorization if written documentation is not available in a timely manner; however, we’re not required to approve claims for which we haven’t received written documentation.

The following services may extend beyond the 90-day continuity of care period, and we will continue the entire course of treatment with the member's current provider as described below:

- Prenatal and postpartum care — We'll continue to pay for services provided by a pregnant member's current provider for the entire course of a pregnancy, including the completion of a woman's postpartum care up to 12 months after birth, regardless of whether the provider is in the Simply network.
- Transplant services — We'll continue to pay for services provided by the current provider for one year post-transplant regardless of whether the provider is in the Simply network.
- Oncology (radiation and/or chemotherapy services) — We'll continue to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in the Simply network.
- Hepatitis C treatment drugs — We'll continue to pay for the full course of therapy.

No service will be denied for absence of authorization in circumstances where care was in place prior to the transition date.

The continuity of care provisions stated above apply to both participating and nonparticipating Simply providers.

Continuity of Care: Provider Termination

Simply allows members to continue receiving medically necessary services from a non-for-cause terminated provider and will process claims for services rendered to such members, until the member selects another provider, for a minimum of 90 days after termination of the provider contract. For continuity of care services under these circumstances, Simply will continue to abide by the same contract terms in place prior to contract termination.

For members moving enrollment from one Florida Healthy Kids subsidized plan to another Florida Healthy Kids subsidized plan (without a break in coverage), there is a 60-day continuity of care period.

5 SIMPLY HEALTHCARE BENEFITS AND COPAYMENTS

Simply Covered Services

Any modification to covered services will be distributed via a provider update by mail, fax, provider newsletter, provider manual addendum and/or contractual amendment. Covered services include those listed below and may vary by product.

Statewide Medicaid Managed Care services

Service	Coverage/Limitations	PA
Addictions Receiving Facility Services Services used to help people who are struggling with drug or alcohol addiction	As medically necessary	Not required
Allergy Services Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover blood or skin allergy testing and up to 156 doses per year of allergy shots.	Not required
Ambulance Transportation Services Ambulance services are for when members need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary.	Required for nonemergent transportation services
Ambulatory Detoxification Services Services provided to people who are withdrawing from drugs or alcohol	As medically necessary	Required
Ambulatory Surgical Center Services Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary. For dental services: Payment responsibility for non-emergency dental outpatient services performed in Ambulatory Surgical Centers (ASC) and hospital outpatient will be processed through the health plan rather than dental plans. Therefore, the dental plans will remain responsible for anesthesia and sedation services when these services are provided in conjunction with dental treatment in an office when medically necessary.	May be required for certain procedures
Anesthesia Services Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary.	Not required
Assistive Care Services Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year.	Required

Service	Coverage/Limitations	PA
Behavioral Health Assessment Services Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover: • One initial assessment per year. • One reassessment per year. • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day).	Not required
Behavior Analysis (BA) Services Highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.	We cover: • Adaptive behavior treatment • Group adaptive behavior treatment • Family adaptive behavior treatment • All services specified in the BA Policy Manual	Required
Behavioral Health Overlay Services Behavioral health services provided to children (ages 0 to 18) enrolled in a DCF program	We cover 365/366 days of services per year, including therapy, support services, and aftercare planning	Required
Cardiovascular Services Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor: • Cardiac testing • Cardiac surgical procedures • Cardiac devices	May be required for cardiac testing and surgical procedures
Child Health Services Targeted Case Management Services provided to children (ages 0 to 3) to help them get healthcare and other services	Child must be enrolled in the DOH Early Steps program.	Required
Chiropractic Services Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover: • One new patient visit. • 24 established patient visits per year. • Maximum of one visit per day. • X-rays. • Ultrasound or electrical stimulation.	Not required
Clinic Services Healthcare services provided in a county health department, federally qualified health center or a rural health clinic		Not required

Service	Coverage/Limitations	PA
Clinical Trials Biomedical or behavioral research studies on human participants designed to answer specific questions about biomedical or behavioral interventions including new treatments and known interventions that warrant further study and comparison.	Florida Medicaid reimburses for services as a result of a recipient participating in a clinical trial in accordance with the service-specific coverage policy when the services: • Are covered under the Florida Medicaid program • Would otherwise be provided to a recipient who is not participating in a clinical trial • Are related to complications or side effects arising during the clinical trial • Are not expected or unique to the experimental or investigational treatment • Are not covered by the clinical trial sponsor	Required
Community-Based Wrap-Around Services Services provided by a mental health team to children who are at risk of going into a mental health treatment facility	As medically necessary	Required
Crisis Stabilization Unit Services Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary	Not required
Dialysis Services Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies and other supplies that help treat the kidneys.	As prescribed by a treating doctor, we cover: • Hemodialysis treatments • Peritoneal dialysis treatments	Required
Drop-In Center Services Services provided in a center that helps homeless people get treatment or housing		Not required
Durable Medical Equipment and Medical Supplies Services Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away.	Some service and age limits apply. Call **844-405-4296** (TTY **711**) for more information.	May be required for some DME or medical supplies.

Service	Coverage/Limitations	PA
Early Intervention Services Services to children ages 0 to 3 who have developmental delays and other conditions	We cover: • One initial evaluation per lifetime, completed by a team. • Up to three screenings per year. • Up to three follow-up evaluations per year. • Up to two training or support sessions per week.	Not required
Emergency Transportation Services Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary.	Required for air ambulances
Evaluation and Management Services Services for doctor's visits to stay healthy and prevent or treat illness	We cover: • One adult health screening (check-up) per year. • Well-child visits, based on age and developmental needs. • One visit per month for people living in nursing facilities. • Up to two office visits per month for adults to treat illnesses or conditions.	Not required
Family Therapy Services Services for families to have therapy sessions with a mental health professional	We cover up to 26 hours per year of family or individual therapy services, one hour per day.	Not required
Family Training and Counseling for Child Development Services to support a family during their child's mental health treatment	As medically necessary	Required
Gastrointestinal Services Services to treat conditions, illnesses, or diseases of the stomach or digestion system	Covered as medically necessary.	May be required for diagnostic tests and procedures
Genitourinary Services Services to treat conditions, illnesses, or diseases of the genitals or urinary system	Covered as medically necessary.	May be required for diagnostic tests and procedures
Group Therapy Services Services for a group of people to have therapy sessions with a mental health professional	We cover up to 39 hours per year.	Not required

Service	Coverage/Limitations	PA
Hearing Services Hearing tests, treatments and supplies that help diagnose or treat problems with hearing. This includes hearing aids and repairs.	We cover hearing tests and the following, as prescribed by a doctor: • Cochlear implants. (If medically necessary) • One new hearing aid per ear, once every three years repairs. • Up to three pairs of ear molds per year. • One fitting and dispensing service per ear every three years. • One hearing test every three years to determine the need for hearing aid and the most appropriate hearing aid. • Up to two newborn hearing screenings for recipients under 12 months of age; a second screening may be performed only if the recipient does not pass the first hearing screening in one or both ears.	Required for cochlear implants and bone anchored hearing aids
Home Health Services Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	We cover: • Up to four visits per day for pregnant recipients and recipients ages 0 to 20. • Up to three visits per day for all other recipients.	Required
Hospice Services Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	Covered as medically necessary.	Required
Individual Therapy Services Services for people to have one-to-one therapy sessions with a mental health professional	We cover up to 26 hours per year of family or individual therapy services, one hour per day.	Not required
Infant Mental Health Pre and Post Testing Services Testing services by a mental health professional with special training in infants and young children	As medically necessary	Required
Inpatient Hospital Services Medical care members get while in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors, and equipment used to treat members	We cover the following inpatient hospital services based on age and situation: • Up to 365/366 days for recipients ages 0 to 20. • Up to 45 days for all other recipients (extra days are covered for emergencies).	Required

Service	Coverage/Limitations	PA
Integumentary Services Services to diagnose or treat skin conditions, illnesses, or diseases	Covered as medically necessary.	Requires PCP referral
Laboratory Services Services that test blood, urine, saliva, or other items from the body for conditions, illnesses or diseases	Covered as medically necessary.	Required for genetic testing
Medical Foster Care Services Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families.	Required
Medication Assisted Treatment Services Services used to help people who are struggling with drug addiction	• Covered as medically necessary. • 52 visits per year.	Not required
Medication Management Services Services to help people understand and make the best choices for taking medication	• Covered as medically necessary. • 52 visits per year.	Not required
Mental Health Partial Hospitalization Program Services Treatment provided for more than three hours per day, several days per week, for people who are recovering from mental illness	As medically necessary	Required
Mental Health Targeted Case Management Services to help get medical and behavioral health for people with mental illnesses	Covered as medically necessary.	Required
Mobile Crisis Assessment and Intervention Services A team of healthcare professionals who provide emergency mental health services, usually in people's homes	As medically necessary	Not required
Neurology Services Services to diagnose or treat conditions, illnesses, or diseases of the brain, spinal cord, or nervous system	Covered as medically necessary.	May be required for diagnostic tests and procedures
Non-Emergency Transportation to and from all Medicaid covered medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no other means of transportation: • Out-of-state travel. • Transfers between hospitals or facilities. • Escorts when medically necessary.	PA is required for out-of-state travel and transfers between hospitals or facilities. PA is required for one-way trips greater than 50 miles.

Service	Coverage/Limitations	PA
Nursing Facility Services Medical care or nursing care that members get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term.	We cover 365/366 days of services in nursing facilities as medically necessary.	Required
Occupational Therapy Services Occupational therapy includes treatments that help members do things in their daily life, like writing, feeding themselves, and using items around the house.	For children ages 0 to 20 we cover: • One initial evaluation per year. • One therapy reevaluation every five months. • Up to 14 therapy treatment units per week and maximum of four units per day. • Up to two casting and strapping applications per day. • One initial wheelchair evaluation per five years. For adults (21 and over) we cover: • One initial evaluation per year. • One therapy reevaluation every year. • Up to 7 therapy units per week. For people of all ages, we cover: • Follow-up wheelchair evaluations, one at delivery and one six months later.	Required
Oral Surgery Services Services that provide teeth extractions (removals) and to treat other conditions, illnesses, or diseases of the mouth and oral cavity	Covered as medically necessary.	Required
Orthopedic Services Services to diagnose or treat conditions, illnesses, or diseases of the bones or joints	Covered as medically necessary.	May be required for diagnostic tests and procedures
Outpatient Hospital Services Medical care members get while in the hospital, but not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors, and equipment used to treat members	• Emergency services are covered as medically necessary. • Nonemergency services cannot cost more than $1,700 per year for recipients ages 21 and over.	Required for nonemergent services

Service	Coverage/Limitations	PA
Pain Management Services Treatments for long-lasting pain that does not get better after other services have been provided	• Covered as medically necessary. Some service limits may apply. • Up to 12 facet joint injections in a six-month period • Up to four percutaneous radiofrequency neurolysis in a four-month period	Required
Physical Therapy Services Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	For children ages 0 to 20 we cover: • One initial evaluation per year. • One therapy re-evaluation every five months. • Up to two casting and strapping applications per day. • Up to 14 therapy treatment units per week and maximum of four units per day. • One initial wheelchair evaluation per five years. For adults (21 and over) we cover: • One initial evaluation per year. • One therapy reevaluation every year. • Up to 7 therapy units per week. For people of all ages, we cover: • Follow-up wheelchair evaluations, one at delivery and one six months later.	Required
Podiatry Services Medical care and other treatments for the feet	We cover: • Up to 24 office visits per year. • Foot and nail care. • X-rays and other imaging for the foot, ankle, and lower leg. • Surgery on the foot, ankle, or lower leg.	May be required for certain procedures/surgeries
Prescribed Drug Services This service is for drugs that are prescribed by a doctor or other healthcare provider	We cover: • Up to a 31-day supply of drugs, per prescription. • Refills, as prescribed. • Up to two 72-hour emergency supplies per prescription within 30 consecutive days.	Authorization required for some drugs
Private Duty Nursing Services Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover up to 24 hours per day.	Required

Service	Coverage/Limitations	PA
Psychological Testing Services Tests used to detect or diagnose problems with memory, IQ, or other areas	We cover 10 hours of psychological testing per year.	Required
Psychosocial Rehabilitation Services Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money, and performing household chores.	We cover up to 480 hours per year.	Required
Radiology and Nuclear Medicine Services Services that include imaging such as X-rays, MRIs, or CAT scans. They also include portable X-rays.	• Covered as medically necessary. • Up to two biophysical profiles per pregnancy. • One fetal echocardiography per pregnancy; up to two follow-up tests for high-risk pregnancy. • One mammography screening per year. • Up to three obstetrical ultrasounds per pregnancy. Additional ultrasounds require appropriate corresponding diagnosis codes indicating medical necessity and modifier TH.	May be required for some radiological procedures or High-Tech Radiology
Regional Perinatal Intensive Care Center Services Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary.	Not required

Service	Coverage/Limitations	PA
Reproductive Services Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help plan family size.	We cover family planning services. Members can get these services and supplies from any Medicaid provider; they do not have to be a part of our plan. PA is not required; these services are free. These services are voluntary and confidential, even for members under 18 years old. Restricted coverage: • From 0 to 15 weeks, elective/on demand abortions are never covered by Medicaid except in cases of rape or incest. Proper documentation is required. • From 0 to 26 weeks, termination of a pregnancy to protect the life of the pregnant woman or a fatal fetal anomaly is covered. Proper documentation is required. • Ectopic pregnancies are covered and are not considered abortions. • Removal of a trophoblastic cyst is covered and is not considered abortion. • Treatment of incomplete miscarriages (sometimes called an incomplete abortion) and non-living fetus (fetal death) is covered and not considered an abortion.	May be required for some services
Respiratory Services Services that treat conditions, illnesses, or diseases of the lungs or respiratory system	We cover: • Respiratory testing. • Respiratory surgical procedures. • Respiratory device management.	May be required for diagnostic tests and procedures
Respiratory Therapy Services Services for recipients ages 0 to 20 to help members breathe better while being treated for a respiratory condition, illness, or disease	We cover: • One initial evaluation per year. • One therapy re-evaluation per six months. • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day).	Not required
Self-Help/Peer Services Services to help people who are in recovery from an addiction or mental illness	As medically necessary	Not required
Specialized Therapeutic Services Services provided to children ages 0 to 20 with mental illnesses or substance use disorders	We cover: • Assessments. • Foster care services. • Group home services.	Required

Service	Coverage/Limitations	PA
Speech-Language Pathology Services Services that include tests and treatments to help members talk or swallow better	For children ages 0 to 20, we cover: • Communication devices and services. • Up to 210 minutes of treatment per week. • One initial evaluation per year. • One re-evaluation every five months. For adults, we cover: • One communication evaluation per five years.	Required
Statewide Inpatient Psychiatric Program Services Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0 through 17.	Required
Substance Use Intensive Outpatient Program Services Treatment provided for more than three hours per day, several days per week, for people who are recovering from substance use disorders.	As medically necessary	Required
Substance Use Short-term Residential Treatment Services Treatment for people who are recovering from substance use disorders.	As medically necessary	Required
Therapeutic Behavioral On-Site Services Services provided by a team to prevent children ages 0 to 20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility.	We cover up to nine hours per month.	Required
Transplant Services Services that include all surgery and pre - and post-surgical care.	Covered as medically necessary.	Required
Visual Aid Services Visual aids are items such as glasses, contact lenses, and prosthetic (fake) eyes.	When prescribed by a doctor, we cover: • Two pairs of eyeglasses for children ages 0 to 20. • Contact lenses. • Prosthetic eyes.	May be required for prosthetic devices
Visual Care Services Services that test and treat conditions, illnesses, and diseases of the eyes	Covered as medically necessary.	May be required for procedures and some tests

Florida Healthy Kids Services

Benefit	Limitations	Copays

Inpatient Services
All covered services provided for the medical care and treatment of a member admitted as an inpatient to a hospital licensed under part I of Chapter 395
 	
Covered services include: physician's services; room and board; general nursing care; patient meals; use of operating room and related facilities; use of intensive care unit and services; radiological, laboratory and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; special duty nursing; radiation and chemotherapy; respiratory therapy; administration of whole blood plasma; physical, speech and occupational therapy; medically necessary services of other health professionals
	• Simply must authorize all admissions.
	• The length of the patient stay is determined based on the medical condition of the member in relation to the necessary and appropriate level of care.
	• Room and board may be limited to semi-private accommodations unless a private room is considered medically necessary or semi-private accommodations are not available.
	• Private duty nursing is limited to circumstances where such care is medically necessary.
	• Admissions for rehabilitation and physical therapy are limited to 15 days per contract year.
	• Inpatient services do not include experimental or investigational procedures defined as a drug, biological product, device, medical treatment, or procedure that meets any one of the following criteria as determined by Simply:
	  ○ Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials.
	  ○ Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy in comparison to conventional alternatives.
	  ○ Reliable evidence shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.
	• PA required
		None

Benefit	Limitations	Copays

Emergency Services
Includes visits to an emergency room or other licensed facility within the U.S. and its territories if needed immediately due to an injury or illness, and delay means risk of permanent damage to the member's health
 	
Covered services also means inpatient and outpatient services furnished by a qualified provider, per *§1932(b)(2)* and *42 CFR 438.114(a)*, and are needed to evaluate or stabilize an emergency medical condition.
	• Simply must also comply with the provisions of § 641.513, Florida Statutes.
	• Subject to the provisions of federal and state law, the member has the right to use any hospital or other setting for emergency care.
	• Simply is responsible for any post-stabilization services obtained within or outside of the network that are preapproved by Simply, or where such approval has been sought by the facility or provider and Simply has failed to respond within one hour of such request for further post stabilization services that are administered to maintain, improve, or resolve the member's stabilized position.
	• Simply limits noncovered charges to members for post stabilization care services to an amount not greater than what the facility or provider would charge the member if the member had obtained the services through Simply.
	• If we did not preapprove post stabilization care, our financial responsibility ends when one of the following occur:
	  ○ An in-network provider with privileges at the treating facility assumes responsibility for the member's care.
	  ○ An in-network provider assumes responsibility for the member's care through transfer.
	  ○ The member is discharged.
		$10 per visit; waived if admitted or authorized by PCP

Maternity Services and Newborn Care Includes maternity and newborn care, prenatal and postnatal care, initial inpatient care of adolescent participants, including nursery charges, and initial pediatric or neonatal examination	• The infant is covered for up to three days following birth or until the infant is transferred to another medical facility, whichever occurs first. • Coverage may be limited to the fee for vaginal deliveries.	None
Organ Transplantation Services Includes pretransplant, transplant, and post discharge services and treatment of complications after transplantation	• Coverage is available for transplants and medically related services if deemed necessary and appropriate by the Organ Transplant Advisory Council or the Bone Marrow Transplant Advisory Council as may be applicable. • PA required	None

Benefit	Limitations	Copays

Outpatient Services
Preventive, diagnostic, therapeutic, palliative care, and other services provided to a member in the outpatient portion of a health facility licensed under Chapter 395
 	
Includes well-child care, including those services recommended in the Guidelines for Health Supervision of Children and Youth as developed by Academy of Pediatrics; immunizations and injections as recommended by the Advisory Committee on Immunization Practices; health education counseling and clinical services; family planning services; vision screening; hearing screening; clinical radiological, laboratory and other outpatient diagnostic tests; ambulatory surgical procedures; splints and casts; consultation with and treatment by referral physicians; radiation and chemotherapy; chiropractic services; and podiatric services
	• Services must be provided directly by Simply or through preapproved referrals.
	• The PCP must provide the routine hearing screening and immunizations.
	• Family planning is limited to one annual visit and one supply visit each 90 days.
	• Chiropractic services are provided in the same manner as in the Florida Medicaid program.
	• Podiatric services are limited to one visit per day, totaling two visits per month for specific foot disorders.
	• Dental services must be provided by an oral surgeon for medically necessary reconstructive dental surgery due to injury. Treatment for temporomandibular joint (TMJ) disease is specifically excluded.
	
	Restricted coverage:
	• From 0 to 15 weeks, elective/on demand abortions are never covered by Medicaid except in cases of rape or incest. Proper documentation is required.
	• From 0 to 26 weeks, termination of a pregnancy to protect the life of the pregnant woman or a fatal fetal anomaly is covered. Proper documentation is required.
	• Ectopic pregnancies are covered and are not considered abortions.
	• Removal of a trophoblastic cyst is covered and is not considered abortion.
	• Treatment of incomplete miscarriages (sometimes called an incomplete abortion) and non-living fetus (fetal death) is covered and not considered an abortion.
	• Outpatient services do not include experimental or investigational procedures defined as a drug, biological product, device, medical treatment, or procedure that meets any one of the following criteria as determined by Simply:
	  ○ Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular member is the subject of ongoing phase I, II or III clinical trials.
	  ○ Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular member is under study with a
		$5 per office visit; no copay for well-child care, preventive care, or routine vision and hearing screenings

Benefit	Limitations	Copays
	written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives. • Reliable evidence shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services. • May require prior authorization for certain procedures	
Mental Health Services Includes inpatient and outpatient care for psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional	• Covered services include inpatient and outpatient services for behavioral health and emotional health disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. • Such benefits include psychological or psychiatric evaluation, diagnosis, and treatment by a licensed mental health professional meeting the requirements of Section 3-2-2(C) of the state contract. • Any benefit limitations, including duration of services, number of visits, or number of days for hospitalization or residential services, will not be any less favorable than those for physical illnesses.	Inpatient: none Outpatient: none
Substance Use Services Includes coverage for inpatient and outpatient care for drug and alcohol abuse, including counseling and placement assistance Outpatient services include evaluation, diagnosis, and treatment by a licensed practitioner.	• Covered services include inpatient, outpatient, and residential services for substance disorders. • Such benefits include evaluation, diagnosis, and treatment by a licensed professional meeting the requirements of Section 3-2-2(C) of the state contract. ○ Any benefit limitations, including duration of services, number of visits, or number of days for hospitalization or residential services, will not be any less favorable than those for physical illnesses.	Inpatient: none Outpatient: none
Therapy Services Includes physical, occupational, respiratory, and speech therapies for short-term rehabilitation where significant improvement in the member's condition will result	• All treatments must be performed as authorized by Simply. • Therapy services are limited to up to 24 treatment sessions within a 60-day period per episode or injury, with the 60-day period beginning with the first treatment.	$5 per visit

Benefit	Limitations	Copays
Home Health Services Includes prescribed home visits by both registered and licensed practical nurses to provide skilled nursing services on a part-time intermittent basis	• Coverage is limited to skilled nursing services only. • Meals, housekeeping, and personal comfort items are excluded. • Services must be provided directly by Simply. • Private duty nursing is limited to circumstances where such care is medically appropriate.	$5 per visit
Hospice Services Includes reasonable and necessary services for palliation or management of a member's terminal illness	Services required for conditions totally unrelated to the terminal condition are covered to the extent that such services are otherwise covered under this contract.	$5 per visit
Nursing Facility Services Covered services include regular nursing services, rehabilitation services, drugs and biologicals, medical supplies, and the use of appliances and equipment furnished by the facility	• All admissions must be authorized by Simply and provided by a Simply-affiliated facility. • Participant must require and receive skilled services on a daily basis as ordered by an in-network physician. • The length of the member's stay is determined by the medical condition of the member in relation to the necessary and appropriate level of care, but it cannot be more than 100 days per contract year. • Room and board is limited to semi-private accommodations unless a private room is considered medically necessary or semi-private accommodations are not available. • Specialized treatment centers and independent kidney disease treatment centers are excluded. • Private duty nurses, television and custodial care are excluded. • Admissions for rehabilitation and physical therapy are limited to 15 days per contract year.	None
Durable Medical Equipment and Prosthetic Devices Equipment and devices medically indicated to assist in the treatment of a medical condition and specifically prescribed as medically necessary by the member's in-network physician	• Equipment and devices must be provided by an authorized Simply supplier. • Covered prosthetic devices include artificial eyes, limbs, braces, and other artificial aids. • Low vision and telescopic lenses are not included. • Hearing aids are covered only when medically indicated to assist in the treatment of a medical condition. • PA may be required for some DME or medical supplies.	None

Benefit	Limitations	Copays
Refractions Examination by a Simply optometrist to determine the need for and to prescribe corrective lenses as medically indicated	• The member must have failed vision screening by their PCP. • Corrective lenses and frames are limited to one pair every two years unless head size or prescription changes. • Coverage is limited to frames with plastic or SYL non-tinted lenses.	$5 per visit; $10 for corrective lenses
Pharmacy Prescribed drugs for the treatment of illness or injury	• This benefit includes all prescribed drugs covered under the Florida Medicaid program; some may require prior authorization. • Please refer to the Pharmacy section of the provider website for the Preferred Drug Lists for FHK and Medicaid. • Simply is responsible for the coverage of any drugs prescribed by the member's dental provider under FHK. • Brand name products are covered if a generic substitution is not available or where the prescribing physician indicates a brand name is medically necessary. • All medications must be dispensed through Simply or a Simply designated pharmacy. • All prescriptions must be written by the member's PCP, Simply approved specialist or consultant physician, or the member's dental provider.	FHK Members: $5 per prescription for up to a 31-day supply
Transportation Services Emergency transportation as determined to be medically necessary in response to an emergency situation	• Transportation services must be in response to an emergency situation.	$10 per service

Enhanced Benefits

Simply has decided to offer a group of enhanced benefits. The expanded services identified below are additional benefits not included in the Florida MMA/Florida Healthy Kids (FHK) core benefits.

Simply waives all copays for Statewide Medicaid Managed Care Managed Medical Assistance members; providers are prohibited from charging Medicaid member copays for covered services.

Copays are not waived for Florida Healthy Kids members; providers are responsible for collecting copays from Florida Healthy Kids members, and the amount paid by Simply will be the contracted amount less any applicable copays.

Members identified as Native Americans or Alaskan Natives are prohibited from paying any cost-sharing amounts, including copays.

Statewide Medicaid Managed Care Managed Medical Assistance Enhanced Benefits

Service	Coverage/Limitations	Prior Authorization
Acupuncture 30 minutes of acupuncture services	30 minutes of treatment once weekly for up to three months; members 21 years of age and older	Required
Behavioral Health Day Services/Day Treatment Behavioral health day treatment or day care services	Additional 10 units per year of day treatment; one day per week, up to 52 per year of day care services; members 21 years of age and older	Not required
Behavioral Health Medical Services (Drug Screening) Behavioral health medical services (alcohol and other drug screening specimen collection)	Additional eight behavioral health-related medical services per year; members 21 years of age and older	Required
Behavioral Health Medical Services (Medication Management) Medication management for behavioral health or substance use	Additional eight behavioral health-related medical services per year; members 21 years of age and older	Required
Behavioral Health Medical Services (Verbal Interaction) Behavioral health medical services (verbal interaction), mental health, or substance use	Additional eight behavioral health-related medical services per year; members 21 years of age and older	Required
Behavioral Health Screening Services Behavioral health screening services	One additional per year; members 21 years of age and older	Not required

Service	Coverage/Limitations	Prior Authorization
Chiropractic Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	Eligible members will receive 35 additional visits per year; members 21 years of age and older	Required
Computerized Cognitive Behavioral Analysis Health and behavior assessment (in other words, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires)	Unlimited through Simply's online well-being tool; members 21 years of age and older	Not required
Doula services Prenatal and postpartum home visits to provide physical, emotional, and informational support; provides ongoing birthing support throughout labor and delivery process	Unlimited home visits per pregnancy	Not required
Electric Stimulators (pain management) Transcutaneous electrical nerve stimulation (TENS) device for pain management	Members 21 years and older	Required
Hearing Services Hearing assessment, hearing aid assessment, and hearing aids for in or behind the ear	• One evaluation per two years • One assessment per two years • One hearing aid, per ear, per two years • Members 21 years of age and older	Not required
Home Delivered Meals — Post-Facility Discharge (Hospital or Nursing Facility) Home delivered meals, including preparation (per meal)	Two meals per day for seven days; must be after three-day or more surgical hospital stay; members 5 years of age and older	Required
Home delivered meals — Disaster Preparedness/Relief 5 Shelf stable meals delivered at home in an affected area with governor declared state of emergency.	First 500 members requesting per line of business (Simply MMA and HIV/AIDS Plan); members 18 years of age and older	Not required
Home Health Nursing/Aide Services Nursing services and medical assistance provided in members' homes to help them manage or recover from a medical condition, illness, or injury	One additional unit of service per day; members 21 years of age and older	Required

Service	Coverage/Limitations	Prior Authorization
Housing Assistance Supported housing, per month	$500 per lifetime for homeless individuals, age 21+	Required
Substance Use Intensive Outpatient Treatment Alcohol and/or drug services; intensive outpatient	Three hours per day, three days per week, nine hours per week, maximum eight weeks; pregnant women 21 to 54 years of age	Required
Massage Therapy Therapeutic procedures involving massage, mobilization, manipulation, or manual traction for pain relief	Unlimited for eligible members, 21 years of age and older	Required
Meals — Nonemergency Transportation Day-Trips Nonemergency transportation and meals for members and required escort to medically necessary doctor visits greater than 100 miles each way	$200 per day; members 21 years of age and older	Required
Newborn Circumcision Circumcision	One per lifetime	Not required
Nutritional Counseling Nutritional counseling, dietitian visit	Six visits per year for eligible members	Not required
Occupational Therapy • Evaluation moderate complexity • Re-evaluation • Treatment visit	One evaluation and re-evaluation per year; up to seven therapy treatment units per week; members 21 years of age and older	Required
Outpatient Hospital Services Medical care members get while they are in the hospital, but not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors, and equipment that is used to treat members.	$200 additional per year, excluding lab services; members 21 years of age and older	May be required* * Refer to online quick tool for exact requirements by CPT code.
Over-the-Counter Benefit Cough, cold, and allergy medications, vitamins, and supplements, ophthalmic/otic preparations, pain relievers, gastrointestinal products, first aid care, hygiene products insect repellent (DEET and non-DEET), oral hygiene products, skin care	Limited to $25 per household per month on an approved list of products	Not required
Physical Therapy • Evaluation moderate complexity • Re-evaluation • Treatment visit	One evaluation and re-evaluation per year; up to seven therapy treatment units per week; members 21 years of age and older	Required

Service	Coverage/Limitations	Prior Authorization
Prenatal Services — Prenatal/Perinatal Visits • Breast pump rental for breast feeding • Antepartum management: 14 visits for low-risk pregnancies and 18 visits for -high-risk pregnancies • Postpartum care: Three visits within 90 days following delivery	Breast pump: one per two years; rental only	Required
Primary Care Visit Services for Adults Services for doctor's visits to stay healthy and prevent or treat illness	Unlimited visits for members 21 years of age and older	Not required
Respiratory Supplies Supplies needed for use of approved positive airway pressure device	Members 21 years and older	Not required
Respiratory Therapy • Initial evaluation and re-evaluation • Respiratory therapy visit	One per year for members 21 years of age and older	Not required
Speech Therapy/Speech Language Pathology • Evaluation/re-evaluation • Evaluation of swallowing function • Speech therapy visit • Augmentative and alternative communication (AAC) initial evaluation/re-evaluation • AAC fitting, adjustment, and training visit	One evaluation/re-evaluation per year; up to seven therapy treatment units per week; one AAC evaluation/re-evaluation per year; up to 30 minutes AAC fitting adjustment and training sessions per year; members 21 years of age and older	Required
Therapy — Art Activity therapy, such as music, dance, art, or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session	Unlimited visits for members receiving behavioral health services	Required
Vaccine — Pneumonia (Pneumococcal) • Pneumococcal conjugate vaccine 13 valent intramuscular • Pneumococcal polysaccharide vaccine 23 valent adult or immunosuppressed dosage subcutaneous or intramuscular	Adults 21 to 64 years of age when medically necessary; adults 65 years or older	Not required
Vaccine — Influenza • Influenza virus vaccine split virus preservative free intramuscular • Influenza virus vaccine	Members 21 years of age and older	Not required

Service	Coverage/Limitations	Prior Authorization
Vaccine — Shingles (Varicella-Zoster) • Zoster shingles vaccine live • Subcutaneous/medicine-immunization administration	One vaccine per member per lifetime, for members 50 years of age and older	Not required for Simply MMA members. PA required for HIV/AIDS Plan members.
Vaccine — TDaP Tetanus diphtheria toxoids acellular pertussis vaccine (TDaP) intramuscular	One vaccine per pregnancy; members 21 years of age and older	Not required
Vision Services Eye exam exclusively to screen visual acuity without need of reported vision problem, illness, disease, or injury; contact lenses; frames	One exam per year; one frame per year; six months of contact lenses with prescription; members 21 years of age and older	Not required
Waived Copayments The plan waives copays on the following services: birthing center; chiropractic; community behavioral health; FQHC; inpatient and outpatient hospital; independent labs; nonemergency transportation; ARNP; optometrist; physician assistant; physician; podiatrist; portable X-ray; RHC; registered nurse first assistant	Members 21 years of age and older	Not required

Specialty Enhanced Services

Service	Coverage/Limitations	Prior Authorization
Acupuncture As an alternative to pain management	As an alternative to pain management; members 21 years of age and older	Required
Behavioral Health Medical Services (Drug Screening) Behavioral health medical services (alcohol and other drug screening)	Additional eight screenings per year; members 21 years of age and older	Required
Behavioral Health Medical Services (Medication Management) Medication management for behavioral health	Additional eight services per year; members 21 years of age and older	Required
Behavioral Health Medical Services (Assessment Services) Behavioral health medical services (assessment services),	Unlimited assessment services; members 21 years of age and older	Required
Chiropractic Diagnosis and manipulative treatment to realign the spine, for pain relief, as an alternative to pain management therapy.	Members 21 years of age and older	Required
Doula services Prenatal and postpartum home visits to provide physical, emotional, and informational support; provides ongoing birthing support throughout labor and delivery process	Unlimited home visits per pregnancy and up to 3 months after delivery; pregnant members ages 13-54	Not required
Hearing Services Hearing assessment, hearing aid assessment, and hearing aids for in or behind the ear	• One evaluation per 24 months • One assessment per 24 months • One hearing aid per ear per 24 months • Members 21 years of age and older	Not required
Home Delivered Meals — Post-Facility Discharge (Hospital or Nursing Facility) Home delivered meals, including preparation (per meal)	Two meals per day for seven days; must be after three-day or more surgical hospital stay; members 5 years of age and older	Required
Home Health Nursing/Aide Services Nursing services and medical assistance provided in members' homes to help them manage or recover from a medical condition, illness, or injury	One additional visit per day; members 21 years of age and older	Required
Housing Assistance Supported housing	$500 per lifetime for homeless individuals; members 21 years of age and older	Required

Service	Coverage/Limitations	Prior Authorization
Massage Therapy Therapeutic procedures involving massage, mobilization, manipulation, or manual traction for pain relief	Unlimited for eligible members, 21 years of age and older	Required
NEMT Day Trip Meals — Nonemergency Transportation Nonemergency transportation and meals for members and required escort to medically necessary doctor visits greater than 100 miles each way	$200 per day	Required
Newborn Circumcision Circumcision	One per lifetime; Male newborn	Not required
Nutritional Counseling Nutritional counseling, dietician visit	Unlimited counseling sessions for enrollees ages 21 and older	required
Occupational Therapy • Evaluation moderate complexity • Re-evaluation • Treatment visit	One evaluation and re-evaluation per year; up to seven therapy treatment sessions per week; members 21 years of age and older	Required
Outpatient Hospital Services Medical care members get while they are in the hospital, but not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors, and equipment that is used to treat members.	$200 additional per year, excluding lab services; members 21 years of age and older	Required* * Refer to online quick tools for exact requirements by CPT code.
Over-the-Counter Benefit Cough, cold, and allergy medications, vitamins, and supplements, eye drops, pain relievers, gastrointestinal products, first aid care, hygiene products insect repellent (DEET and non-DEET), oral hygiene products, skin care	Limited to $65 per household per month	Not required
Physical Therapy • Evaluation moderate complexity • Re-evaluation • Treatment visit	One evaluation and re-evaluation per year; up to seven therapy treatment sessions per week; members 21 years of age and older	Required
Respiratory Supplies Supplies needed for use of approved positive airway pressure device	Members 21 years and older	Required

Service	Coverage/Limitations	Prior Authorization
Speech Therapy/Speech Language Pathology • Evaluation/re-evaluation • Evaluation of swallowing function • Speech therapy visit • AAC initial evaluation/re-evaluation • AAC fitting, adjustment, and training visit	One evaluation/re-evaluation per year; up to seven therapy treatment units per week; one AAC evaluation/re-evaluation per year; up to 30 minutes AAC fitting adjustment and training sessions per year; members 21 years of age and older	Required
Therapy — Art, Equine, Pet Activity therapy, art, equine, or pet therapies not for recreation.	Members must be in BH case management	Required
Vaccine — Pneumonia (Pneumococcal) • Pneumococcal conjugate vaccine 13 valent intramuscular • Pneumococcal polysaccharide vaccine 23 valent adult or immunosuppressed dosage subcutaneous or intramuscular	Members 21 years of age or older	Not required
Vaccine — Hepatitis B Hepatitis B vaccine, adult dosage	Members 21 years or older, who have not been previously vaccinated are eligible to receive the vaccine.	Not required
Vaccine — Human Papilloma Virus HPV vaccine	All adults ages 21 to 45 who have not previously received the vaccine are eligible	Not required
Vaccine — Influenza Annual flu shot	Members 21 years of age or older; one per year	Not required
Vaccine — Meningococcal Meningococcal vaccine	Members 21 years of age or older two doses at least two months apart per member per every five years	Not required
Vaccine — TDaP Tetanus diphtheria toxoids acellular pertussis vaccine (TDaP)	Pregnant members 21 years of age or older; One vaccine per member per lifetime	Not required
Adult Vision Services Routine Eye exam exclusively to screen visual acuity without need of reported vision problem, illness, disease, or injury	One routine eye exam per year; one frame per year; **or** six months of contact lenses with prescription; members 21 years of age and older	Not required
Waived Copays The plan waives copays on certain services, such as: birthing center; community behavioral health; FQHC; inpatient and outpatient hospital; independent labs; nonemergency transportation; optometrist; physician assistant; physician; podiatrist; portable X-ray; RHC		Not required

Florida Healthy Kids Expanded Benefits

- $10 a month to buy certain personal care items and over-the-counter (OTC) medicines
- $100 for hypoallergenic bedding (if medically needed)
- Our 24-hour Nurse HelpLine to answer medical questions anytime at **866-864-2544** (TTY **711**)
- Non-Emergent Transportation Services — Up to 50 roundtrip rides per year for members and 1-2 companions to their scheduled nonurgent medical, dental, and specialist visits

Taking Care of Baby and Me® Program

Taking Care of Baby and Me® is a proactive care management program for all perinatal members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification may include state enrollment files, claims data, and hospital census reports, as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure the appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. They may also collaborate with community partners to facilitate connecting members to local and national agencies who can assist with services and support.

When it comes to pregnancy, we are committed to keeping both parent and baby healthy.
That is why we encourage all our pregnant and postpartum members to take part in our Taking Care of Baby and Me program, a comprehensive program which offers:

- Individualized, one-on-one complex care management support for pregnant members at the highest risk
- Care coordination for those members who may need a little extra support
- Digital perinatal educational tools
- Information on community resources
- Incentives to encourage members to keep up with checkups and well-child visits after the baby is born
- Proactive care coordination and complex care management support for parents of infants that are admitted to the neonatal intensive care unit (NICU)

As part of the Taking Care of Baby and Me® program, perinatal members have access to a digital offering. This digital offering is available by smartphone app and provides pregnant and postpartum members with timely, proactive, and culturally appropriate education. Once members are identified as pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allow us to assess their pregnancy risk.

After risk assessment is complete, the app delivers gestational-age-appropriate education directly to the member. This program does not replace the high-touch, individual case management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure education is available to all perinatal members and help Simply to identify members who experience a change in risk acuity throughout the perinatal period.

We require notification of pregnancy at the first prenatal visit and notification of delivery following birth. Please refer to the provider website to access forms: **Provider Forms** (**simplyhealthcareplans.com**)**.** Please complete the **FL Medicaid Pregnancy Notification Form** and email it to dl-shpcm_dm_referrals@simplyhealt hcareplans.com or fax the completed form to Simply at **877-577-0117**. You may choose to complete the notification of delivery in Availity Essentials or fax the form to Simply at **800-964-3627**.

We also ask that providers complete the Maternity Application in **Availity Essentials** during the initial E&B request performed on a pregnant member. The information obtained during this process supports our effort to identify pregnancies as early as possible so that we may notify eligible members of various perinatal resources, including the care management program. The steps to complete the Maternity Application are detailed below:

- **Perform an Eligibility and Benefits (E&B) request on the desired member.**
- **Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.**
- **If the appropriate conditions apply for payer, user, member and service type, the maternity question screen will display. Conditions include:**
    - **The member is female**
    - **The member is 45 years of age or under**
    - **The member is 15 years of age or over**
- **If the member is not pregnant, select no and submit to continue to the E&B response screen.**
- **If the member is pregnant, select yes and submit. You will be prompted to enter additional dates if known:**
    - **The Estimated Due Date**
    - **The first prenatal appointment date**
- **When YES is selected, the maternity data entered is saved for this member.**
- **After submitting your answer, the E&B response screen will display.**

We encourage healthcare providers to share information about the Taking Care of Baby and Me program and the digital maternity tools offered at Simply with members. Members may access information about the products that are available by visiting the Simply member website.

For more information about the Taking Care of Baby and Me program or the digital maternity tools, reach out to Provider Services at **844-405-4296,** or refer to our provider websites.

Neonatal Intensive Care Unit (NICU) Care Management

If a baby is born premature or with a serious health condition, they may be admitted to the NICU. We believe the more parents know, the better they will be able to care for their infant. To support them, we have a NICU Case Management program.

We extend our support by helping parents to prepare themselves and their homes for when baby is released from the hospital. After baby is home, our care managers continue to provide education and assistance in improving baby's health, preventing unnecessary hospital readmissions, and guiding parents to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns that parents may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping parents engage with hospital-based support programs
- Facilitating parent screenings for potential PTSD
- Connecting parents with behavioral health program resources and community support as needed
- Actively asking for their feedback on the provided resources and how an increased awareness of PTSD has helped

For more information about our NICU Care Management program, reach out to Provider Services at **844-405-4296** or refer to our provider website at **provider.simplyhealthcareplans.com/florida-provider/maternal-child-services**.

Community Partnerships to Improve Outcomes (CPIO) Program

The health plan partners with community organizations to support the health outcomes of our Medicaid, specialty condition (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.

Quality Enhancement Program

Simply offers quality-enhanced programs for the benefit of members and providers. These include:

1. Children's programs — We provide regular general wellness programs for ages birth to 5 years, or we make a good faith effort to involve members in existing community children's programs.
    a. We rely on providers seeing children to provide prevention and early intervention services for at-risk members. We approve claims for services recommended by the early intervention programs when they are covered services and medically necessary.
    b. We offer annual training to providers (through monthly provider agendas, the Simply website) that promote proper nutrition, breastfeeding, immunizations, wellness, prevention, and early intervention services.
2. Domestic violence programs — We require PCPs to screen members for signs of domestic violence and require PCPs to offer referral services to applicable domestic violence prevention community agencies.
3. Pregnancy prevention — We conduct pregnancy prevention programs or make a good faith effort to involve members in existing community pregnancy prevention programs. These programs will be targeted toward teen enrollees but be open to all ages.
4. Prenatal/postpartum pregnancy programs — We provide regular home visits by a home health nurse or aide and offer counseling and educational materials to pregnant and postpartum members who are not in compliance with the health plan's prenatal and postpartum programs. We will coordinate our efforts with the local Healthy Start care coordinator to prevent duplication of services. We require that all providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate. We require that all providers give all women of childbearing age HIV counseling and offer them HIV testing.
5. Smoking cessation — We provide smoking cessation counseling to members. We provide participating PCPs with a quick reference card to help identify tobacco users and support delivery of effective smoking cessation interventions. Please see the "Smoking Cessation Program" section below.
6. Substance use programs — We offer annual substance use screening training to our providers. In addition, several screening tools and other resources are available on our provider website to help providers identify substance use and make appropriate referrals.
    a. At a minimum, all PCPs are required to screen members for signs of substance use as part of prevention evaluation at the following times:
        i) During initial contact with a new member
        ii) During routine physical examinations
        iii) During initial prenatal contact
        iv) When the member displays serious overutilization of medical, surgical, trauma, or emergency services
        v) When documentation of emergency room visits suggests the need
    b. Providers identifying patients with substance use needs should refer patients to community substance use programs.

Encounter submission is critical to ensuring the quality of services by validating the work providers perform. To obtain credit for services rendered, all providers must submit encounters when including providers contracted under a capitated arrangement.

Well-Child Visits/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Statewide Medicaid Managed Care Managed Medical Assistance, and MediKids Members

Simply members are encouraged to contact their physician within the first 90 days of enrollment to schedule a well-child visit and within 24 hours for newborns. Simply members are eligible to receive these services from birth to age 20. For EPSDT members, if a service is medically necessary, it must be covered, regardless of whether the service is on the fee schedule or not. This applies to all EPSDT members under 21 years of age.

Note: EPSDT requirements are applicable to Medicaid and MediKids.

The program provides the following:

- Comprehensive health and development history
- Physical and mental development assessment
- Comprehensive unclothed physical examination
- Age-appropriate immunizations
- Appropriate laboratory tests
- Health education

Newborn well-child services should be performed for newborns in the hospital and then at the following ages:

- 3 to 5 days old
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

In the child's second year of life, they should see a PCP at 15 months, 18 months, 24 months and 30 months of age. During the span of a child's third year of life until age 20, the child should be seen by their PCP at least on an annual basis. Simply educates our members about these guidelines and monitors encounter data for compliance.

Simply recommends that participating providers who treat children under the age of 21 use the American Academy of Pediatrics Bright Futures well-child forms to ensure all aspects of an EPSDT visit are captured. The forms are at **aap.org/en/practice-management/bright-futures** (Materials and Tools).

Simply requires providers to:

- Participate in the EPSDT program if they treat children under the age of 21.
- Provide all needed initial, periodic, and interperiodic EPSDT health assessments, diagnosis, and treatment to all eligible members in accordance with the Florida Agency for Health Care Administration's approved Medicaid administrative regulation Section. III C.9.b and the periodicity schedule provided by the American Academy of Pediatrics (AAP).
- Refer members to an out-of-network provider for treatment if the service is not available within our network.
- Provide vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
- Provide vaccinations in conjunction with EPSDT/well-child visits; providers are required to use vaccines available without charge under the Vaccine for Children (VFC) program for Medicaid children 18 years of age and younger (excludes MediKids).
- Address unresolved problems, referrals, and results from diagnostic tests, including results from previous EPSDT visits.

- Request a prior authorization for a medically necessary EPSDT special service in the event other healthcare, diagnostic, preventive, or rehabilitative services or treatment, or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Florida Medicaid program.
- Monitor, track, and follow up with members:
  - Who have not had a health assessment screening.
  - Who miss appointments, to assist them in obtaining an appointment.
- Ensure members receive the proper referrals to treat any conditions or problems identified during the health assessment, including tracking, monitoring, and following up with members to ensure they receive the necessary medical services.
- Assist members with transition to other appropriate care for children who age-out of EPSDT services.

Simply recommends that participating providers who administer immunizations to children under the age of 18 use the Centers for Disease Control (CDC) Immunization Schedule for Persons Aged 0 through 18. This schedule is located at **cdc.gov/vaccines/imz-schedules**.

Well-Child Visits Reminder Program

Based on Simply claims data, we send a list of members who may not have received wellness services according to schedule to the members' PCPs each quarter. Additionally, we mail information to these members encouraging them to contact their PCPs' offices to set up appointments for needed services. Please note:

- The specific service(s) needed for each member is listed in the report; reports are based only on services received during the time the member is enrolled with Simply.
- Services must be rendered on or after the due date in accordance with federal EPSDT and state Department of Health guidelines. In accordance with these guidelines, services received prior to the specified schedule date do not fulfill EPSDT requirements.
- This list is generated based on Simply claims data received prior to the date printed on the list; in some instances, the appropriate services may have been provided after the report run date.
- To ensure accuracy in tracking preventive services, please submit a completed claim form for those dates of service to the Simply Claims department at:

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

Blood Lead Testing Requirements

During every well-child visit for children between the ages of 6 months and 6 years, the PCP should screen each child for lead poisoning. Simply requires all PCPs to test for high blood lead levels assuring compliance with CMS requirements. These requirements state that all Medicaid enrollees must have a blood lead test performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months, up to 72 months, should receive a blood lead test if there is no past record of a test.

We encourage providers to contact Medtox to receive supplies to test children's blood lead levels in their offices. With a simple finger prick and a drop of blood on the filter paper from Medtox, the member will not have to go to another provider/lab to have the services done. Once you return the sample by mail, Medtox will send you the results and bill Simply for the test.

For those children who have a blood level greater than or equal to 10, continued testing is required until the blood level is below 10.

Vaccines for Children for Medicaid Recipients

The VFC program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of an inability to pay. VFC was created by the Omnibus Budget Reconciliation Act of 1993 as an entitlement program to be a required part of each state's Medicaid plan. The program was officially implemented in October 1994.

Funding for the VFC program is approved by the Office of Management and Budget and allocated through CMS to the Centers for Disease Control and Prevention (CDC). CDC buys vaccines at a discount and distributes them to grantees (that is, state health departments and certain local and territorial public health agencies) that then distribute them at no charge to those private physicians' offices and public health clinics registered as VFC providers.

Simply requires our providers to participate in the VFC program and have sufficient vaccine supplies. For additional information on the VFC program, visit **cdc.gov/vaccines-for-children/about**.

Family Planning Services

Members have direct access to both network and non-network providers for all family planning services, including exams, assessments, and traditional contraceptive devices. Services are not covered for members under the age of 18 unless they are married, a parent, pregnant, or will suffer health hazards if services are not provided. FHK coverage of family planning is limited to one annual visit and one visit for a supplier every 90 days. Oral and injectable contraceptives and condoms are always covered for MMA members 12 and older and FHK members 10 and older.

Healthy Rewards — Healthy Behaviors Rewards Program

We offer programs to members who want to stop smoking, lose weight, or address any drug use problems, and we reward members who join and meet certain goals. We also offer Well Child Visit programs, and Asthma Management. Our Healthy Rewards Programs include:

- Smoking/Tobacco cessation program.
- Weight management program.
- Alcohol and substance use program.
- Maternal child program, including:
  - SBIRT (Screening, Brief, Intervention, Referral, and Treatment) screening
  - Medication for Opioid Use Disorder (MOUD)
- Well Child Visits
- Asthma Management
- HIV Management

Setting Healthy Goals

The Simply Healthy 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/about-cancer/causes-prevention/risk/tobacco/cessation-fact-sheet	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.

Audiology Services
Simply provides audiology services in line with those offered by Florida Medicaid, plus additional expanded benefits for Medicaid members.

Outpatient Laboratory and Radiology Services
All outpatient laboratory tests should be performed at a network facility, an outpatient lab, or at one of the Simply preferred network labs (LabCorp) unless the test is a Clinical Laboratory Improvement Amendments (CLIA)-approved office test. Visit the CMS website at **cms.hhs.gov** for a complete list of approved accreditation organizations under CLIA. Carelon Medical Benefits Management, Inc. provides diagnostic radiology management services and will provide precertifications for CAT scans, MRA, MRI, nuclear cardiology, and PET scans. Contact Carelon Medical Benefits Management at **800-252-2021** or **providerportal.com** for more information.

Claims that are submitted for laboratory services subject to the 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.

Pharmacy Services

The Simply pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to national pharmacy chains and many independent retail pharmacies.

Covered Drugs

The Simply Pharmacy program uses a *Preferred Drug List* (*PDL*). This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. To prescribe medications that do not appear on the *PDL*, you may initiate an electronic prior authorization request through **covermymeds.com**. Prescribers may also call Pharmacy Services at **877-577-9044** or fax a completed Pharmacy Prior Authorization Form to **877-577-9045** for retail pharmacy requests and **844-509-9862** for medical injectable requests. Please refer to the Pharmacy Prior Authorization Form, MMA, and Florida Healthy Kids PDLs, and prior authorization criteria links on our provider website.

Drugs Requiring Prior Authorization

Providers are strongly encouraged to write prescriptions for preferred products as listed on the appropriate *PDL* for that member (either MMA or FHK). If a member cannot use a preferred product because of a medical condition, providers are required to contact Simply Pharmacy Services to obtain prior authorization. To request prior authorization, call the Pharmacy department at **877-577-9044** or fax a completed Pharmacy Prior Authorization Form (available on the provider website) to **877-577-9045** for retail pharmacy requests and **844-509-9862** for medical injectable requests. You may also initiate electronic prior authorization requests through **covermymeds.com**. Providers must be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria.

Over-The-Counter Drugs

Simply provides coverage of several OTC drugs when accompanied by a prescription. The following are examples of covered OTC medication classes. Providers should consult the MMA and FHK *PDL*s for specifics on covered products and limits (members may be able to access OTC products under the Value-Added OTC Benefit):

- Analgesics/antipyretics
- Antacids
- Antifungals, topical
- Antifungals, vaginal
- Antihistamines
- Antihistamine-decongestant combinations
- Emergency contraceptives
- Cough and cold preparations
- Iron replacement supplements
- Laxatives
- Pediculicides
- Respiratory agents (including spacer devices)
- Select vitamins and multi-vitamins

Excluded Drugs

The following drugs are some examples of medications that are excluded from the pharmacy benefit:

- Weight control
- Drugs used for cosmetic reasons (hair growth or hair removal)
- Erectile dysfunction drugs to treat impotence
- Drugs that duplicate therapy
- Prescription drugs that Simply is prohibited from making payment due to Federal or State law or per State Medicaid agency guidance

Informed Consent for Psychotherapeutic Medications for Children (Statewide Medicaid Managed Care Managed Medical Assistance Members)
Pursuant to *F.S.A. 409.912(13)*, the Agency for Health Care Administration (AHCA) may not pay for a psychotropic medication prescribed for a child under the age of 13 years in the Medicaid program without the express and informed consent of the child's parent or legal guardian. The physician must document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription.

The psychotherapeutic drugs include (but are not limited to) antipsychotics, antidepressants, anti-anxiety medications, and mood stabilizers. Certain anti-convulsant and ADHD medications (that is, stimulants and nonstimulants) are not included at this time (subject to change). A signed *Informed* Consent Form must be presented to the pharmacy with each new prescription for an affected drug for a member under 13 years of age. Consent forms are available at **ahca.myflorida.com/medicaid/prescribed-drugs/behavioral-health-medication-management-resources**.

Note: copies of the consent form must be maintained in the member's medical records.

Carved Out Medications
Hemophilia drugs are an excluded service from the health plan's Medicaid benefit package. They are covered through the fee-for-service Statewide Medicaid Comprehensive Hemophilia Disease Management Program.

The Agency for Health Care Administration (Agency) entered into a contract with CVS Caremark (Vendor) to fulfill the responsibilities of the Statewide Medicaid Comprehensive Hemophilia Management Program. The Vendor's contract combines the provision of pharmaceutical products, pharmaceutical management, and disease management (for example, treatment and prevention of bleeding episodes, medical consultation, home infusion education, training, twenty-four hours per day, seven days a week access to a registered nurse and a licensed pharmacist) for the Florida Medicaid recipients diagnosed with hemophilia or Von Willebrand disease.

Should you have any questions about the Hemophilia Disease Management Program, please feel free to contact:

- The Agency's Provider and Recipient Assistance Bureau
  Monday – Friday, 8:00 a.m. EST - 5:00 p.m. EST
  877-254-1055 (TDD **866-467-4970**) or online at **flmedicaidmanagedcare.com/home/contact**
- CVS Caremark
  Monday – Friday, 8:00 a.m. EST - 5:00 p.m. EST
  888-826-5621 Option 4

There are no carved-out medications for FHK members.

Behavioral Health Services

Overview

Pursuant to the Simply contract with AHCA and the state MMA plan, Simply will provide coverage, via its subcontractor Carelon Behavioral Health, for a full range of behavioral health services (that is, treatment for psychiatric and emotional disorders), including community mental health services and mental health targeted case management services to all members in contracted counties. Simply will provide coverage of mental health and substance use disorder treatment for Florida Healthy Kids members residing in the counties in which Simply participates as part of the member's behavioral health benefit.

Primary and Specialty Services

PCPs are encouraged to screen members for behavioral health and alcohol and drug abuse conditions as part of the initial assessment and subsequent visits as needed.

Age-appropriate examples of validated behavioral health screening and assessment tools for children and adolescents:

- **ADHD: NICHQ Vanderbilt Assessment Scale**
- **ADHD: ADHD Rating Scale-Home Version**
- **Anxiety: Generalized Anxiety Disorder-7 (GAD-7)**
- **Autism: Modified Checklist for Autism in Toddlers Revised (M-CHAT-R)**
- **Autism: First Signs Screening Tools**
- **Depression: Adolescent Patient Health Questionnaire-9 (PHQ9)**
- **Substance Use Disorder: The CRAFFT Screening Interview**
- **Substance Use Disorder: AUDIT-PC Screening Tool**
- **Substance Use Disorder: CAGE Questionnaire - Alcohol Screening tool**

Additional behavioral health and substance use disorder assessment tools can be found on our website: **provider.simplyhealthcareplans.com/florida-provider/behavioral-health**.

A PCP can offer covered behavioral health and/or alcohol and drug abuse services when:

- Services are within the scope of the PCP's license.
- The member's current condition is not so severe, confounding, or complex as to warrant a referral to a mental health and alcohol and drug abuse provider.
- The member is willing to be treated by the PCP.
- Services are within the scope of the benefit plan.

PCPs are encouraged to educate members with behavioral health and/or alcohol and drug abuse conditions about the nature of the condition and its treatment. As appropriate, PCPs are also encouraged to educate members about the relationship between physical and behavioral health and alcohol and drug abuse conditions.

Referral for Mental Health and Alcohol and Drug Abuse Conditions

Members may self-refer, or providers may direct members to the Simply network of behavioral health providers.

Experienced behavioral health clinicians are available 24 hours a day, 7 days a week by calling the automated Provider Services line at **844-405-4296** to assist with identifying the closest and most appropriate behavioral health service.

Behavioral Health Claims
Submit paper behavioral health claims to:

Carelon Behavioral Health
Claims Department
P.O. Box 1850
Hicksville, NY 11802-1850

Behavioral Health Emergency Services
Behavioral health emergency services are those services that are required to meet the needs of an individual who is experiencing an acute behavioral health or emotional crisis. Examples of behavioral health and alcohol and drug abuse emergency medical conditions are when:

- The member is suicidal.
- The member is homicidal.
- The member is a danger to themselves or others.
- The member has suffered a severe decline in functional impairment and is unable to take care of their activities of daily living.
- The member is alcohol or drug-dependent, and there are signs of severe withdrawal.

Behavioral Health Medically Necessary Services
Simply defines medically necessary behavioral health services as those that are:

- Reasonably expected to treat and prevent the onset of an illness, condition, or disability; reduce or ameliorate the physical, behavioral, or developmental effects of an illness, condition, injury or disability; and assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities appropriate for members of the same age.
- Reasonably expected to provide an accessible and cost-effective course of treatment or site of service that is equally effective in comparison to other available, appropriate, and substantial alternatives and is no more intrusive or restrictive than necessary.
- Sufficient in amount, duration, and scope to reasonably achieve their purpose as defined in federal law.
- Of a quality that meet standards of medical practice and/or healthcare generally accepted at the time services are rendered.

Behavioral Health Coordination of Care
Simply, through its contracted and community providers and case management services, will be responsible for the coordination and active provision of continuity of care for all members. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. Additionally, Simply will coordinate medical and behavioral health services as dictated by the needs of the members.

The exchange of medical information facilitates behavioral and medical health care collaboration. For example, if the PCP obtains the member's consent via the *Authorization for Release of Information* form, the form is completed and sent to the behavioral health provider. The behavioral health provider may use the release as necessary for the administration and provision of care.

Self-Referral Services

The following services do not need a referral from a PCP:

- Emergent care (regardless of network status with Simply)
- Family planning (regardless of network status with Simply)
- Behavioral health assessments (nonparticipating providers must seek prior approval from Simply)
- OB care (nonparticipating providers must seek prior approval from Simply)
- Well-woman/GYN care (nonparticipating providers must seek prior approval from Simply)
- EPSDT/well-child services (nonparticipating providers must seek prior approval from Simply)
- Tuberculosis, STD, HIV/AIDS testing and counseling services (regardless of network status with Simply)

Member Rights and Responsibilities

Florida law requires that providers or healthcare facilities recognize the rights of members while they are receiving medical care and that members respect the healthcare provider's or healthcare facility's right to expect certain behavior on the part of members. Members may request a copy of the full text of this law from their healthcare provider or healthcare facility. The following is a summary of the member's rights and responsibilities (see *Section 381.026, Florida Statutes*).

Patients' Rights

Patients have a right to:

- Be treated with respect and with due consideration for dignity and privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for their care.
- A right to receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities
- A right to make recommendations regarding the organization's member rights and responsibilities policy
- Know what member support services are available, including whether an interpreter is available if they don't speak English.
- Know what rules and regulations apply to their conduct.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to their conditions and ability to understand, regardless of cost or benefit coverage.
- Be given the opportunity to be involved in decisions involving their healthcare, except when such participation is contraindicated (not recommended) for medical reasons.
- Refuse treatment.
- Be given healthcare services in line with federal and state regulations.
- Be given, upon request, full information and necessary advice of available financial help for their care.
- Receive, upon request, before treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a reasonably clear and easy-to-understand itemized bill and, upon request, have the charges explained.
- Impartial access to medical treatment or accommodations, no matter of race, national origin, religion, physical handicap, or source of payment.
- Treatment for any emergency medical condition that will get worse from not getting the proper treatment.
- Know if medical treatment is for experimental research and give consent or refusal to be involved in that research.

- File grievances and appeals regarding any violation of their rights, as stated in Florida law, through the grievance procedure to the health plan, healthcare provider, or healthcare facility that served them and to the appropriate state licensing agency.
- Be free from any form of restraint (control) or seclusion used as coercion (force), discipline, convenience, or retaliation (revenge).
- Ask for and get a copy of their medical records and ask that those records be updated or corrected.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage

Patients' Responsibilities

Patients have the responsibility to:

- Provide their healthcare provider, to the best of their knowledge, correct and complete information about present complaints, past illnesses, hospitalizations, medications (including over-the-counter products), dietary supplements, any allergies or sensitivities, and other matters relating to their health.
- Report unexpected changes in their conditions to their healthcare providers.
- Report to their healthcare providers whether they understand a planned action and what is expected of them.
- Participate in developing the mutually agreed upon treatment plan recommended by their healthcare provider and follow the plan and instructions.
- Keep appointments and, when not able to for any reason, tell the healthcare provider or healthcare facility.
- Understand their actions if they refuse treatment or don't follow the healthcare provider's instructions.
- Inform their providers about any living wills, medical powers of attorney, or other directives that could change their care.
- Make sure the needs of their healthcare are met as quickly as possible.
- Follow healthcare facility rules and regulations about member care and conduct.
- Behave in a way that is respectful of all healthcare providers and staff as well as of other members.

First Line of Defense Against Fraud

General Obligation to Prevent, Detect, and Deter Fraud, Waste, and Abuse

Healthcare fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the healthcare industry may be perpetuated by every party involved in the healthcare process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation, and reporting.

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 (FWA) 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.

Help prevent member and provider fraud by identifying the different types so you can be the first line of defense.

Examples of Provider Fraud, Waste, and Abuse:

- 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

Providers can help prevent fraud, waste, and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records, and billed according to American Medical Association guidelines.

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 letting us know
- Using someone else's ID card
- Subrogation and/or third-party liability fraud
- Transportation fraud

To help prevent fraud, waste, and abuse, providers can educate members about the types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse.

One of the most important steps to help prevent member fraud is reviewing the Simply member ID card; it's the first line of defense against fraud. Simply may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member even if that patient presents a Simply member ID. Providers should take measures to ensure the cardholder is the person named on the card. Additionally, encourage members to protect their cards as they would a credit card or cash, carry their Simply member ID at all times, and report any lost or stolen cards to Simply as soon as possible.

We believe awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste, or abuse, and working with members to protect their Simply ID cards can help prevent fraud, waste, and abuse.

Learn more at **fighthealthcarefraud.com**.

Reporting Possible FWA

As a Simply provider and a participant in government-sponsored healthcare, you and your staff are obligated to report suspected fraud, waste, and abuse. 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.

You can report your concerns by:

- Visiting our **fighthealthcarefraud.com** education site; at the top of the page, select **Report it** and complete the **Report Waste, Fraud and Abuse** form
- Calling Provider Services at **844-405-4296**
- Calling Member Services at **844-406-2396 (Medicaid)**
- Calling our SIU and reporting anonymously at **866-847-8247**.

Direct concerns for Florida Health Kids to **844-405-4298**.

As an alternative, you can also report suspected fraud or abuse in Florida Medicaid directly to the Agency for Health Care Administration by calling their Consumer Complaint Hotline toll-free at **888-419-3456** or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at **apps.ahca.myflorida.com/mpi-complaintform**. If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other healthcare provider, you may be eligible for a reward through the Inspector General's Fraud Rewards Program. You can call the Inspector General's office at **866-866-7226** (toll-free). The reward may be up to 25% of the amount recovered or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's office about keeping your identity confidential and protected.

No individual who reports violations or suspected fraud, waste, or abuse will be retaliated against, and Simply will make every effort to maintain anonymity and confidentiality.

When reporting concerns involving a **provider** (for example, doctor, dentist, counselor, medical supply company) include:

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

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 mailed 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 a provider or facility against any payments due and payable by Simply to the provider or facility with respect to any Health Benefit Plan under any contract with our company, regardless of the cause. The 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 Simply that an overpayment amount is due from a provider or facility, the provider or facility must refund the overpayment amount within the timeframe specified in the 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 the provider or facility under any Health Benefit Plan in accordance with regulatory requirements. Should the provider or facility disagree with any determination, the provider or facility shall have the right to appeal such determination under Simply procedures set forth in this Provider Manual, on condition that such appeal shall not suspend Simply's 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.

Relevant Legislation

To meet the requirements under the Deficit Reduction Act, each provider must adopt the Simply fraud, waste, and abuse policies and distribute them to any of your staff or contractors. If you have questions or would like to have more details concerning the Simply fraud, waste, and abuse detection, prevention, and mitigation program, please contact Provider Services at **844-405-4296**.

As a recipient of funds from federally and state-sponsored healthcare programs, we each have a duty to help prevent, detect, and deter fraud, waste, and abuse. Simply's commitment to detecting, mitigating, and preventing fraud, waste and abuse is outlined in our Corporate Compliance Program. Electronic copies of this policy and the Simply Code of Business Conduct and Ethics are available at **provider.simplyhealthcareplans.com** and **provider.clearhealthalliance.com**.

HIPAA

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.

Simply strives to ensure that both Simply and contracted 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 following procedures implemented to demonstrate compliance with the HIPAA privacy regulations:

- We recognize our responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Simply:
    - Please note, privacy regulations allow the transfer or sharing of member information, which may be requested by Simply to conduct business and make decisions about care (such as a member's medical record), 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 Simply, verify the receiving fax number is correct, notify the appropriate staff at Simply and verify the fax was appropriately received.
- Email (unless encrypted) should not be used to transfer files containing member information to Simply (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.
- Use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, post office box or department at Simply.
- The Simply voicemail 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 Simply, please be prepared to verify the provider's name, address, and tax identification number, national provider identifier, or Simply provider ID.

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.

6 MEMBER MANAGEMENT SUPPORT

Welcome Call

As part of our member management strategy, Simply offers a welcome call to new members. During the welcome call, new members are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist the member with any current needs such as scheduling an initial checkup.

Appointment Scheduling

Through our participating providers, we ensure members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a Simply member's needs and requests in a timely manner, per the guidelines outlined in the **Access and Availability** section.

24/7 NurseLine

The Simply 24/7 NurseLine is designed to support providers by offering information and education to members after hours about medical conditions, healthcare, and prevention. Members can call **844-406-2396**. The same number is also listed on the member's ID card. We provide triage services and help direct members to appropriate levels of care. This ensures members have an additional avenue of access to healthcare information when needed. Features of the 24/7 NurseLine include:

- Availability 24 hours a day, 7 days a week.
- Information based on nationally recognized and accepted guidelines.
- Free translation services for 150 different languages and for members that are deaf or hard of hearing.
- Education for members regarding appropriate alternatives for handling nonemergent medical conditions.
- Faxing of the member's assessment report to the provider's office within 24 hours of receipt of a call.

24/7 Pharmacy Member Services

The CarelonRx Pharmacy Member services hotline is available for members 24/7 to provide assistance related to the pharmacy benefit. Simply Medicaid members can call **833-214-3607,** and FHK members can call **833-267-3110** for assistance.

Interpreter Services

Interpreter services are available if needed (including language translation services and Braille). Simply provides interpreter services, free of charge, for enrollees whose primary language is not English. Interpretation services are provided by Voiance, which offers over 100 different languages and corresponding interpreters. Additionally, language translation services are available for enrollees who are hearing-impaired. Effective physician-patient communication is critical in improving comprehension, utilization, clinical outcomes, patient satisfaction, and quality of care. It is important that patients and their providers are aware of available interpreter services and know how to access them.

How providers can access these services:

- Identify members with limited English proficiency.
- Ask these members if they prefer to communicate in a language other than English.
    - If yes, provide them with information regarding the available interpreter services. You or the member can call Member Services at **844-406-2396** and ask for assistance.

Health Promotion

Simply strives to improve healthy behaviors, reduce illness, and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and then disseminated to

our members, and health education classes are available through in-network community organizations and providers.

Ongoing projects that offer our members education and information regarding their health include:

- A newsletter to members at least once a year.
- Creation and distribution of a Simply health education tool newsletter used to inform members of health promotion issues and topics.
- Health Tips on Hold — educational telephone messages that play while the member is on hold.
- A monthly member calendar of health education programs.
- Development of health education curricula and procurement of other health education tools (for example, breast self-exam cards).
- Relationship development with community-based organizations to enhance opportunities for members.
- Available community resources via the Simply website at **simplyhealthcareplans.com**.
- **FindHelp** – an online platform that helps manage and coordinate social services and community resources in the area for patients.

Case Management

Case management is designed to proactively respond to a member's needs when conditions or diagnoses require care and treatment for long periods of time. When a member is identified (usually through initial health risk assessment process, a predictive model, precertification, admission review, and/or provider or member request), the Simply case manager helps to identify the appropriate case management program and any medically appropriate alternative methods or settings in which care may be delivered.

A provider, on behalf of the member, may refer them to case management. The clinician will work with the member, provider and/or the hospital to identify the necessary:

- Intensity level of case management services needed.
- Appropriate alternate settings where care may be delivered.
- Healthcare services required.
- Equipment and/or supplies required.
- Community-based services available.
- Communication required (that is, between the member and PCP as well as other providers).

During an admission, the Simply case manager will assist the member, utilization review team, and PCP and/or hospital in developing the discharge plan of care, ensuring that the member's medical needs are met, and linking the member with community resources and Simply programs for outpatient case and/or disease management.

Please note, a Simply case manager cannot perform services that are limited to providers, such as overriding a prior authorization requirement for prescription medications.

Behavioral Health Case Management

Members do not need to see their PCP before getting behavioral health services. If members need help finding mental health, alcohol, and drug abuse services, they can call toll free at **844-375-7215** for MMA, **844-280-9633** for the HIV/AIDS Plan, and **855-861-2142** for FHK. For the 24/7 crisis line, they should call **844-375-7215** and select **9** for Emergency to be transferred to a clinician.

HIV/AIDS Specialty Care Case Management

The HIV/AIDS Specialty Plan provides members with comprehensive case and condition care. Our program includes care coordination across the continuum of care as well as secondary and tertiary prevention interventions. These services are based on a comprehensive, multidisciplinary, and system-wide approach that encompasses evidence-based guidelines, practitioner practice, and member empowerment strategies to improve members' health outcomes.

Our case management and care coordination staff work with the member's provider, often an HIV specialist (see **Credentialing**), to ensure adherence with HIV antiretroviral therapy and medical care visits. This includes coordination of care for:

- Appointments with primary and specialist providers.
- Transportation.

Case managers assess the acuity level and service the unique needs of each member. They score the results of *Health Risk Assessments* and assign a member risk category. This category is based on specific disease stratification algorithms and may include low, moderate, or high score. Results guide the development of the individualized care plan, and the corresponding interventions designed to improve compliance and health outcomes and prevent acute events. Care plans are:

- Created in collaboration with the member/caregiver, legal guardian, or other legally authorized individual.
- Based on member stratification.
- Designed to address interventions that:
  - Improve member ability to adhere to the physician/provider treatment plan.
  - Improve self-management.
  - Decrease health risks.

We share the care plan with the primary and/or specialist provider(s) for review and feedback. We document, note and/or adjust the care plan as applicable based on any feedback obtained. And when a member receives services from a community agency (for example, Ryan White) with member approval, we share the established care plan as appropriate with the case managers in these agencies to ensure all issues are addressed and there is no duplication of services.

We allow HIV specialists, including infectious disease providers, to be PCPs, which is unique to our plan and increases access to care. These providers, marked with a red ribbon in our provider directory, receive additional training in longitudinal management of HIV/AIDS and frequent comorbidities and bring experience, expertise, and cultural sensitivity to our members. These providers are acutely aware of the incidence and implications of physical and behavioral health comorbidities, and they've developed robust integrated processes to deliver whole-person care.

We work closely with our primary care partners to build capacity for integrated care and expand member access to routine screening and follow-up for behavioral health conditions. The presence of several mental health and substance use diagnoses are known to be common among people living with HIV/AIDS. Simply requires PCPs to routinely screen members for a range of behavioral health and substance use conditions as part of routine, preventive care.

Condition Care Program

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 programs include a holistic approach, focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member self-empowerment.

The ability to manage more than one condition to meet the changing healthcare needs of our member population.

Our condition care programs include:

- Behavioral health:
  - Bipolar Disorder
  - Major Depressive Disorder – Adult
  - Major Depressive Disorder – Child/Adolescent
  - Schizophrenia
  - Substance Use Disorder
- Cardiac:
  - Coronary Artery Disease
  - Congestive Heart Failure
- Alzheimer's/Dementia
- Oncology (active and posttreatment)
- End of life (palliative program)
- Diabetes
- HIV/AIDS
- Hypertension
- Pulmonary:
  - Asthma
  - Chronic Obstructive Pulmonary Disease

In addition to our condition-specific programs, member-centric approach also allows us to assist members with weight management and smoking cessation education.

Program Features

- Proactive population identification processes
- Program content is based on evidence-based clinical practice guidelines
- Collaborative practice models to include physician and support in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are National Committee for Quality Assurance-accredited and incorporate outreach, education, care coordination, and follow-up to improve treatment compliance and enhance self-care.

Simply CNDC programs are based on nationally approved clinical practice guidelines, located on our provider website. A copy of the guidelines can be printed from the website.

Who is Eligible?

Members diagnosed with one or more of the above-listed conditions are eligible for CNDC programs.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and condition care support. Our case managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk-stratified based on the severity of their condition. They are provided with continuous education on self-management concepts, which include primary prevention, coaching healthy behaviors, and compliance/monitoring, as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

CNDC Provider Rights and Responsibilities

The provider has the right to:

- Obtain information about Simply, staff qualifications, and any contractual relations.
- Decline to participate in or work with the Simply programs and services for their patients, depending on contractual requirements.
- Be informed of how Simply coordinates our interventions with treatment plans for individual patients.
- Know how to contact the person's case manager 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 regarding the CNDC program as outlined in the Simply provider complaint and grievance procedure.

Hours of Operation

Simply CNDC case managers are registered nurses and are available Monday to Friday, 8:30 a.m. to 5:30 p.m. ET. Confidential voicemail is available 24 hours a day.

Contact Information

Call **888-830-4300** to reach a case manager or refer to our provider website for additional information about CNDC. Members can obtain information about our CNDC program by visiting **simplyhealthcareplans.com/Medicaid** and **clearhealthalliance.com/member** or calling **888-830-4300**.

Health Management: Healthy Families Program

Program offering families assistance with leading a healthy lifestyle and improving childhood obesity in our members. The Healthy Families program helps members by providing education, community resources, and individualized plans of care over a six-month period. Program offered to members ages 7 to 17. To refer a member, call **844-421-5661,** Monday to Friday from 8:30 a.m. to 5:30 p.m. ET.

Enrollee Advisory Committee

The enrollee advisory committee, sometimes called the member advisory committee, provides advice to Simply regarding member health education and outreach program development. The committee strives to ensure materials and programs meet cultural competency requirements and are both understandable to the member and address the member's health education needs. The committee seeks members' input into the quality improvement projects, in order to improve quality, as needed.

The committee's responsibilities are to:

- Provide input into the annual review of policies and procedures, the QM program results and outcomes, and future program goals and interventions.
- Identify health education needs of the membership based on review of demographic and epidemiologic data.
- Assist the health plan in decision-making in the areas of member grievances, marketing, member services, case management, outreach, health needs, performance improvement projects and cultural competency.
- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program.
- Assist in the review, development, implementation, and evaluation of the member health education tools for the outreach program.
- Review the health education plan and make recommendations on health education strategies.

Women, Infants, and Children Program

The Women, Infants, and Children (WIC) program impacts the health of mothers and children in the medically needy population. Optimal nutritional status during pregnancy and early childhood provides the best chance for the future of Floridians. Medicaid recipients eligible for WIC benefits include the following classifications:

- Pregnant women
- Women who are breastfeeding infant(s) up to one year postpartum
- Women who are not breastfeeding up to six months postpartum
- Infants under the age of 1
- Children under the age of 5

Network providers are expected to coordinate with the WIC program. Coordination includes referral to the local WIC office for all infants and children up to age 5 and pregnant, breastfeeding, and postpartum women.

WIC Referrals

Simply providers are required to refer all infants and children up to age 5 and pregnant, breastfeeding, and postpartum women to the local WIC office. Providers are required to send WIC:

- A completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment).
- Hemoglobin or hematocrit.
- Any identified medical and/or nutritional problems.

For each subsequent WIC certification, providers are required to coordinate with the local WIC office to provide the above referral data from the most recent EPSDT visit. Each time providers complete the WIC referral form, they are required to give a copy to the patient and keep a copy in the patient's medical record. Providers should keep a copy of these documents in the medical record to provide evidence the required process has taken place.

Members may apply for WIC services at their local WIC agency service. Call Provider Services at **844-405-4296** for the agency nearest to the member. For more information, please visit **floridahealth.gov/individual-family-health/womens-health/wic**.

Pregnancy-Related Requirements

Prenatal Risk Screening

Providers seeing Simply members for pregnancy-related diagnoses must:

- See the pregnant member within 30 days of enrollment.
- Complete Florida's Healthy Start prenatal risk screening instrument for each pregnant member as part of her first prenatal visit as required by *Section 383.14, F.S., Section 381.004, F.S.*, and *64C7.009, F.A.C*:*
  - Use the Department of Health prenatal risk form (DH Form 3134), which can be obtained from the local County Health Department (CHD).
  - Retain a copy of all documentation of Healthy Start screenings, assessments, findings, and referrals in the enrollees' medical records.
  - Submit the completed DH Form 3134 to the CHD in the county in which the prenatal screen was completed within ten business days of completion of the screening.
- Collaborate with the Healthy Start care coordinator within the member's county of residence to assure risk-appropriate care is delivered.

* Pregnant members or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

- If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score.
- If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, hepatitis B, substance use, or domestic violence.

Infant Risk Screening
Providers must complete Florida's Healthy Start infant (postnatal) risk screening instrument (DH Form 3135) with the certificate of live birth and transmit the documents to the CHD in the county in which the infant was born within five business days of the birth. Providers must retain a copy of the completed DH Form 3135 in the patient's medical record and provide a copy to the patient.

HIV Testing
Providers are required to give all women of childbearing age HIV counseling and offer them HIV testing (see *Chapter 381, F.S.*):

- Providers, in accordance with Florida law, must offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at 28 to 32 weeks of pregnancy.
- Providers must attempt to obtain a signed objection if a pregnant woman declines an HIV test (see *Section 384.31, F.S.* and *64D3.019, F.A.C.*)
- For those women who are infected with HIV, providers must offer and provide counseling about the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (per the Public Health Service Task Force Report titled *Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States*). To receive a copy of the guidelines, contact the Department of Health, Bureau of HIV/AIDS, at **850-245-4334** or visit **hivinfo.nih.gov/hiv-source/medical-practice-guidelines/hiv-treatment-guidelines/hiv-treatment-guidelines-adults-and**.

Hepatitis B Screenings
Providers are required to:

- Screen all pregnant members receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit.
- Perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant members who tested negative at the first prenatal visit and are considered high-risk for Hepatitis B infection; this test shall be performed at the same time the other routine prenatal screenings are ordered.
- Report all HBsAg-positive women to the local CHD and refer to Healthy Start Program regardless of their Healthy Start screening score.

Hepatitis B and Hepatitis B Immune Globulin Vaccines:

- Infants born to HBsAg-positive members must receive Hepatitis B immune globulin and the Hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth, and complete the Hepatitis B Maxine vaccine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.
- Providers must test infants born to HBsAg-positive members for HBsAg and Hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series to monitor the success or failure of the therapy.
- Providers must report to the local CHD a positive HBsAg result in any child 24 months or younger within 24 hours of receipt of the positive test results.

- Providers must refer infants born to members who are HBsAg-positive to Healthy Start regardless of their Healthy Start screening scores.

Testing Positive for Hepatitis B

Providers are required to:

- Report to the perinatal Hepatitis B prevention coordinator at the local CHD all prenatal or postpartum patients who test HBsAg-positive.
- Report said patients' infants and contacts to the perinatal Hepatitis B prevention coordinator at the local CHD.
- Report the following information: name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or EDC, whether or not the enrollee received prenatal care, and immunization dates for infants and contacts.
- Use the perinatal Hepatitis B case and contact report (DH Form 1876) for reporting purposes.

Providers are required to provide the most appropriate and highest level of quality care for pregnant members, including but not limited to the following:

- Prenatal care:
  - Complete a pregnancy test and a nursing assessment with referrals to a physician, physician assistant, or advanced registered nurse practitioner for comprehensive evaluation.
  - Complete case management through the gestational period according to the needs of the member.
  - Ensure any necessary referrals and follow-up.
  - Schedule return prenatal visits at least every four weeks until week 32, every two weeks until week 36, and every week after until delivery, unless the member's condition requires more frequent visits.
  - Contact those members who fail to keep their prenatal appointments as soon as possible and arrange for their continued prenatal care.
  - Assist members in making delivery arrangements if necessary.
  - Screen all pregnant members for tobacco use and make smoking cessation counseling and appropriate treatment available as needed.
- Nutritional assessment/counseling — Providers are required to:
  - Supply nutritional assessment and counseling to all pregnant members.
  - Ensure the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of breast-milk substitutes.
  - Offer a midlevel nutrition assessment.
  - Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse, or a physician following the nutrition assessment.
  - Keep documentation of the nutrition care plan in the medical record by the person providing counseling.
- Obstetrical delivery — Simply has developed and uses generally accepted and approved protocols for both low-risk and high-risk deliveries, which reflect the highest standards of the medical profession, including Healthy Start and prenatal screening, and requires all providers use these protocols:
  - Providers must document preterm delivery risk assessments in the enrollee's medical record by the 28th week.
  - If the provider determines the member's pregnancy is high-risk, the provider's obstetrical care during labor and delivery must include preparation by all attendants for symptomatic evaluation and as the member progresses through the final stages of labor and immediate postpartum care.
- Newborn care — Providers are required to supply the highest level of care for the newborn beginning immediately after birth. Such level of care shall include, but not be limited to, the following:
  - Instilling prophylactic eye medications into each eye of the newborn

- When the mother is Rh-negative, securing a cord blood sample for type Rh determination and direct Coombs testing
- Weighing and measuring the newborn
- Examining the newborn for abnormalities and/or complications
- Administering 0.5 mg of vitamin K
- Calculating an Apgar score
- Assessing any other necessary and immediate need for referral in consultation with a specialty physician, such as the Healthy Start (postnatal) infant screen
- Administering any necessary newborn and infant hearing screenings (must be conducted by a licensed audiologist pursuant to *Chapter 468, F.S.*; a physician licensed under *Chapters 458* or *459, F.S.*; or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or a licensed audiologist)

- Postpartum care — The provider is required to:
  - Administer a postpartum examination for the member between 7 – 84 (1 – 12 weeks) days post-delivery.
  - Supply voluntary family planning, including a discussion of all methods of contraception as appropriate.
  - Ensure eligible newborns are enrolled with Simply and that continuing care of the newborn is provided through the EPSDT program component.

Healthy Start Program

Healthy Start is a national program that provides comprehensive developmental services for pregnant women, infants, and preschool children up to age 3. We collaborate with community Healthy Start programs to provide timely and age-appropriate health screening and referrals for routine health services.

- Simply provides each member with a community-based PCP.
- Simply encourages Healthy Start staff to refer members to see their PCP for screenings and health services.
- Simply supports timely and complete immunization of all children.
- Simply supports routine dental, vision, and hearing exams for members.
- Simply encourages physical exams in accordance with the EPSDT periodicity schedule.
- Simply supports personal hygiene as part of the child's daily routine through age-appropriate educational programs.
- Simply Member Services, nurse case managers, and Health Promotion staff coordinate the delivery of services for children and work with their caretakers to eliminate barriers to timely healthcare.

Local Health Department

Simply works collaboratively with local health departments. Members have access to any county health department without authorization for the following services:

- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases, such as tuberculosis and HIV
- Immunizations
- Family planning services and related pharmaceuticals
- School health services listed above and services rendered on an urgent basis by such providers
- Adult screening services
- Well-child visits
- Medical primary care services
- Registered nurse services

7 PROVIDER RESPONSIBILITIES

Medical Home

The PCP is the foundation of the medical home, responsible for providing, managing, and coordinating all aspects of the member's medical care and providing all care that is within the scope of their practice. The PCP is responsible for coordinating member care with specialists and conferring and collaborating with the specialists, using a collaborative concept known as a medical home.

Simply promotes the medical home concept to all of its members. The PCP is the member and family's initial contact point when accessing healthcare. The PCP relationship with the member and family, together with the healthcare providers within the medical home and the extended network of consultants and specialists with whom the medical home works, have an ongoing and collaborative contractual relationship. The providers in the medical home are knowledgeable about the member and family's special and health-related social and educational needs and are connected to necessary resources in the community that will assist the family in meeting those needs. When a member is referred for a consultation or specialty/hospital services or for health and health-related services by the PCP through the medical home, the medical home provider maintains the primary relationship with the member and family. They keep abreast of the current status of the member and family through a planned feedback mechanism with the PCP, who receives them into the medical home for continuing primary medical care and preventive health services.

Providers' Bill of Rights

Each healthcare provider who contracts with the Florida Agency for Health Care Administration (AHCA) and/or Florida Healthy Kids or subcontracts with Simply to furnish services to members will be assured of the following rights:

- To advise or advocate (within the lawful scope of practice) on behalf of a member who is their patient for the following:
    - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
    - Any information the member needs to decide among all relevant treatment options
    - The risks, benefits, and consequences of treatment or nontreatment
    - The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the grievance, appeal, and fair hearing procedures
- To have access to the Simply policies and procedures covering the authorization of services
- To be notified of any decision by Simply to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested
- To challenge, on behalf of Medicaid members, the denial of coverage of or payment for medical assistance
- To be free from provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- To be free from discrimination for participation, reimbursement or indemnification when acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification

Provider and Facility Digital Guidelines

Simply understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform providers and facilities about our digital platforms.

Simply expects providers and facilities will use digital tools unless otherwise mandated by law or other legal requirements.

The Digital Guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Simply. These platforms and applications are accessible to both participating and nonparticipating providers and facilities and encompass **Essentials.Availity.com**, electronic data interchange (EDI), electronic medical records (EMR) connections, and business-to-business (B2B) desktop integration.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital functionality available through Availity Essentials include:

1. Acceptance of digital ID cards
2. Eligibility and benefit inquiry and response
3. Prior authorization submissions, including updates, clinical attachments, authorization status, and clinical appeals
4. Claim submission, including attachments, claim status
5. Remittances and payments
6. Provider Enrollment and Network Management
7. Demographic updates

Additional digital applications available to providers and facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management
- Services through Carelon Behavioral Health

Simply expects providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers and facilities using their practice management software and clearinghouse billing vendors.

Providers who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our members transition to digital member ID cards, providers and facilities may need to implement changes in their processes to accept this new format. Simply expects that Providers and facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If providers and facilities require a copy of a physical ID card, members can email a copy of their digital card from their smartphone application, or providers and facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response
Providers and facilities should leverage these Availity clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response:
  - Simply supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials:
  - The Eligibility and Benefits Inquiry verification application allows providers and facilities to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs:
  - Simply has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.
Providers and facilities should leverage these channels for prior authorization submission, status inquiries and submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - Simply supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Simply supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation, including medical records via the HL7 payload.
- Availity Essentials:
  - The Availity Essentials multi-payer Authorization application facilitates prior authorization submission, authorization status inquiry, and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
  - Simply has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software, and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status
<u>Claim submissions status and claims payment disputes</u>

Providers and facilities should leverage these channels for electronic claim submission, attachments (for both pre- and post-payment), and status:

- EDI transaction: X12 837 – professional, institutional, and dental claim submission (version 5010):
  - Simply supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
  - 837 Claim batch upload through EDI allows providers and facilities to upload a batch/file of claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
  - Simply supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – Claims & Payments application
  - The Claims & Payments application enables providers and facilities to enter a claim directly into an online claim form and upload supporting documentation for a defined claim.

    - The Claim Status application enables providers and facilities to access online claim status. Access the claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Simply that electronic claim payment disputes are adopted when and where they are integrated.
- Provider desktop integration via B2B APIs:
    - Simply has also enabled real-time access to Claim status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and facilities should leverage these channels for electronic claim attachments from **Essentials.Availity.com**:

- EDI transaction: X12 275 – patient information, including HL7 payload attachment:
    - Simply supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation, including medical records via the HL7 payload.
- Availity Essentials – Claim Status application
    - The Claim Status application enables providers and facilities to digitally submit supporting claims documentation, including medical records, directly to the claim.
    - Digital Request for Additional Information (Digital RFAI) – the Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Simply supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and facilities can register, enroll, and manage their ERA preference through **Essentials.Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for claims, contact Availity Client Services at **1-800-AVAILITY** (282-4548).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment by reducing administrative processes. There are several options to receive claims payments electronically.

- **Electronic Funds Transfer (EFT)**
  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a provider's or facility's bank account at no charge for the deposit. Health plans can use a provider's or facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

To enroll in EFT: Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient **EnrollSafe User Reference Manual**.

To disenroll from EFT: Providers and facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

- **Virtual Credit Card (VCC)**
  For Providers and facilities who don't enroll in EFT, and in lieu of paper checks, Simply is shifting some reimbursements to virtual credit card (VCC). VCC allows providers and facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

  Note that Simply may receive revenue for issuing a VCC.

  Opting out of virtual credit card payment. Providers and facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

  - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit card payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**
  The Zelis Payment Network (ZPN) is an option for providers and facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

  Note that Simply may receive revenue for issuing ZPN.

  ERA through Availity is not available for providers and facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

Section 6: Provider Enrollment and Network Management

Provider Enrollment

Simplified enrollment process: Professional providers can enroll as a new care provider in our network through Availity Essentials. **Real-Time Tracking**: Providers can track the status of their requests in the **My Dashboard** section of the Provider Enrollment and Network Management application.

My Roster:

Providers and facilities can download roster data through Availity Essentials. This allows the review of data within our system and updates using the formatted file to provide changes.

- To request a roster, go to **Essentials.Availity.com** > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management > Request Current Roster.
- Providers and facilities will be prompted to select the organization name and TIN they would like included in the roster. Multiple TINs can be included in one request.
- A Roster File Submission confirmation message displays. When the roster is ready to download, it will be available by selecting **Download Requested Roster**. Rosters are usually available within 4 hours. Rosters cannot be requested more than once a day.

Providers and facilities can edit the downloaded roster and upload the updated version via Availity's Provider Data Management *Upload Roster File* screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

*See Section 7: Demographic Updates section for more information about Provider Data Management.

Provider access for Provider Enrollment and Network Management features:

- To access these features, go to **Essentials.Availity.com** > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management application.
- For organizations already using Availity Essentials, the organization's Availity Essentials administrator should go to **My Account Dashboard** from the Availity Essentials home page to register new users and update or unlock accounts for existing users. Staff who need access to the Provider Enrollment and Network Management application need to be granted the role of Provider Enrollment.

Section 7: Demographic updates

Provider Data Management (PDM)

Availity Essentials Provider Data Management (PDM) is the digital intake application for providers and facilities to submit demographic change requests – it is also where providers can upload a roster with demographic changes. 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, and follow the prompts.

For provider and facilities using the roster upload option, additional resources are available:

- **Error Report:**
  - Providers and facilities can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.
  - Providers and facilities are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed, and the addition, change, or termination will not be updated in our systems
- **Results Report:** When a roster has the status partially complete or complete a Results Report will be created for any rosters received on and after June 15, 2024. The Results Report is an Excel file that shows the adds and updates made to your provider group's demographic data based on the information contained in a specific roster.
- **Use the *Roster Submission Guide:*** For provider and facilities using the roster upload option, additional information about the Error Report and Results Report can be found in our *Roster Submission Guide*. Find it online at **Essentials.Availity.com** > Payer Spaces > Select Payer Tile > Resources > Roster Submission Guide using Provider Data Management.

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 **Essentials.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 screenshot 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**.

***** Exclusions:

- Behavioral Health providers contracted with Carelon Behavioral Health, 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.

Responsibilities of the PCP

The PCP is a network physician who has responsibility for the complete care of their members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. FQHCs health and RHCs may be included as PCPs. Some of the PCP's responsibilities are listed below:

- All Florida Healthy Kids PCPs must be board-certified pediatricians or family practice physicians.

- All PCPs must provide coverage 24 hours a day, 7 days a week, and regular hours of operation must be clearly defined and communicated to members.
- All PCPs must provide services ethically and legally in a culturally competent manner and meet the unique needs of members with special healthcare requirements.
- The PCP is the coordinator of all care. Therefore, the PCP agrees to ensure continuity of care to Simply members and arrange for the provision of services when the PCP's office is not open. Documentation of emergency room visits, hospital discharge summaries, or operative reports is to be obtained by the PCP and maintained in the medical record.
- The PCP agrees to 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.
- The PCP must conduct a health assessment of all new enrollees within 90 days of the effective date of enrollment.
- When clinically indicated, the PCP agrees to contact Simply members regarding appropriate follow-up of identified problems and abnormal laboratory, radiological, or other diagnostic findings.
- The PCP must establish office procedures to facilitate the follow-up of member referrals and consultations. The PCP is responsible for obtaining and maintaining in the medical record the results or findings of consultant referrals. If findings were communicated through telephonic consultation, a summary of the findings and name of the specialist must be documented.
- The PCP must participate in any system established by Simply to facilitate the sharing of medical records (subject to applicable confidentiality requirements in accordance with *42 CFR, Part 431*, *Subpart F*, including a minor's consultation, examination, and drugs for STDs in accordance with *Section 384.30 (2), F.S.*).
- The PCP agrees, when the need arises, to contact Simply regarding interpretive services via AT&T or other service for members who may require language assistance.
- If a new PCP is added to a group, Simply must approve and credential the provider before the provider may treat members. Notification of changes in the provider staff is the responsibility of the provider's office and must be communicated to Simply in writing.
- The PCP agrees to participate and cooperate with Simply in quality management, utilization review, continuing education, and other similar programs established by Simply.
- The PCP agrees to participate in and cooperate with the Simply grievance and appeal procedures when Simply notifies the PCP of any member complaints or grievances.
- Balance billing for a covered service is not permitted. A Florida Healthy Kids member can only be billed for applicable copays if the copay was not collected at the time the service was rendered.
- If a PCP agreement with Simply is terminated, the PCP must continue care in progress during and after the termination period for up to six months until a provision is made by Simply for the reassignment of members. Pregnant members can continue receiving services through postpartum care. Payment for covered services under this continuity of care period will be made in accordance with the rates effective in the provider's participating agreement at the time of termination.
- The PCP may opt to go bare and not carry malpractice liability insurance, but must follow the requirements under *F.S. 458.320*.
- The PCP must comply with all applicable federal and state laws regarding the confidentiality of member records.
- The PCP must certify to Simply, upon credentialing and recredentialing, that their active patient load does not exceed 3,000 (including all commercial, Medicare, Florida Healthy Kids, other SMMC plan, and children's medical services patients). Patients are defined as active when the PCP sees them at least two times a year.
- The PCP agrees to develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.

- The PCP agrees to establish appropriate policies and procedures to fulfill obligations under the Americans with Disabilities Act (ADA).
- The PCP agrees to support and cooperate with the Simply Quality Management Program to provide quality care in a responsible and cost-effective manner.
- The PCP agrees to provide HIV counseling and offer HIV testing to all members of childbearing age.
- The PCP agrees to refer pregnant women or infants to Healthy Start and WIC programs within 30 days of enrollment.
- The PCP agrees to provide counseling and education in support of Medicaid quality and benefit enhancement (QBE) services, which include children's programs, domestic violence, pregnancy prevention (including abstinence), prenatal/postpartum care, smoking cessation, and substance use programs. The PCP agrees to include information on the programs and community resources encouraged by Simply.
- The PCP agrees to provide counseling and offer the recommended antiretroviral regimen to all pregnant women who are HIV-positive and to refer them and their infants to Healthy Start programs regardless of their screening scores.
- The PCP agrees to offer screening for Hepatitis B surface antigen to all women receiving prenatal care. If they test positive, the PCP agrees to refer them to Healthy Start regardless of their screening score and to provide Hepatitis B Immune Globulin and the Hepatitis B vaccine series to children born to such mothers.
- The PCP agrees to inform Simply if they object to the provision of any counseling, treatments, or referral services on religious grounds.
- The PCP agrees to treat all members with respect and dignity, provide them with appropriate privacy, and treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release in accordance with HIPAA and applicable state laws.
- The PCP agrees to provide members with complete information concerning their diagnosis, evaluation, treatment, and prognosis, and give members the opportunity to participate in decisions involving their healthcare, regardless of whether members have completed an advance directive, except when contraindicated for medical reasons.
- The PCP agrees to an adequate and timely communication among providers and the transfer of information when members are transferred to other healthcare providers. The PCP agrees to obtain a signed and dated release allowing for the release of information to Simply and other providers involved in the member's care.
- The PCP agrees to physically screen members taken into the protective custody, emergency shelter or foster care programs by the Department of Children and Families (DCF) within 72 hours or immediately if required.
- The PCP must ensure food snacks or services provided to members meet their clinical needs and are prepared, stored, secured, and disposed of in compliance with local health department requirements.
- The PCP agrees that provisions will be made to minimize sources and transmission of infection in the office.
- The PCP agrees to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide quality member care.
- The PCP agrees that any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care.
- The PCP agrees to use certified EHR technology in a meaningful manner, as described in the Florida Medicaid EHR Incentive Program.
- The PCP is enrolled in the Florida state Health Online Tracking System (SHOTS) statewide registry. Providers should bill Medicaid Fee-for-Service directly for immunizations provided to Title XXI MediKids participants.
- The PCP agrees to provide immunization information to the DCF upon receipt of members' written permission and DCF's request for members requesting temporary cash assistance from the DCF.

- The PCP agrees to attempt to obtain medical records on any member(s) receiving services from a non-network provider with the proper release specific to any diagnosis signed by the member. These services include, but are not limited to, family planning, preventive services, and sexually transmitted diseases.
- The PCP agrees to maintain vaccines safely and in accordance with specific guidelines, to provide member immunizations according to professional standards, and to maintain up-to-date member immunization records. PCP providers who render immunization to children are required to administer Vaccines in accordance with the Recommended Childhood and Adolescent Immunization Schedule for the United States:
    - Providers who render vaccines to Simply and Title XXI (MediKids and FHK) children are required to enroll with Florida's statewide online immunization registry, the Florida State Health Online Tracking System (SHOTS) and continue to keep the Simply member's immunization record updated in the SHOTS database.
    - Providers must also register with the Vaccines for Children Program to obtain vaccines free of charge for Simply members, excluding MediKids members (Medicaid program codes: MK A, MK B, MK C)
    - The Vaccines for Children (VFC) Program does not provide vaccines for the Title XXI (MediKids and FHK) members. Providers must use their purchased vaccines stock for this population.
    - All claims for immunizations rendered to MediKids, FHK, and Medicaid members must be submitted to Simply for payment:
        - For all Medicaid members, excluding the MediKids population, Simply will render payment for the administration of the vaccines only, as vaccines are expected to be obtained free of charge from the VFC Program.
        - For the Title XXI (MediKids and FHK) members, Simply reimburses at a proprietary fee schedule based on the CDC and Private Sector Pricing for FHK and MediKids vaccine reimbursement. Simply will review for pricing changes and will update its vaccine fee schedule twice a year. Payment for updated pricing changes will be applied prospectively. Simply pays a separate $10.00 fee for the administration of vaccines. In order to be appropriately reimbursed, providers should bill for vaccine administration in addition to the vaccine product on the same claim.
        - Immunization Schedules and Requirements: **floridahealth.gov/individual-family-health/immunization/parents-children-and-adolescents**
        - CDC Vaccine Price List: **cdc.gov/vaccines-for-children/php/price-list**
- The PCP agrees to reach out to members to schedule an appointment for post-discharge or after they are notified the member went to the emergency room.
- The PCP agrees to assist with HIV/AIDS plan eligibility verification through provision of HIV status verification when available.
- The PCP agrees to make provisions to communicate in the language or fashion primarily used by their assigned members.

Simply allows immunizations to be administered at locations other than a PCP's office so long the treating provider submits the information to SHOTS or notifies the Enrollee's PCP of the immunization administration. However, Simply PCPs are prohibited from refusing to proactively offer or administer immunizations at their offices.

Pathways to Purpose Screener

This online tool will allow providers to submit required screening results during their patients' PCP visit and provide the health plan with information gathering to offer resources such as value-added benefits, community-based organizations, and referrals that address barriers to purpose and independence. The online screener will also allow provider tracking of screening completion and trends for type, number, and value of community outreach services provided.

Health Related Social Needs Required Screening

PCPs must conduct screening of at least ninety-five percent (95%) of members for health-related social needs (HRSN) using an industry standard screening tool and record the identified ICD-10 codes (Z55-Z65) in the member's electronic health record. PCPs must provide such codes via claims submissions to the Managed Care Plan. Screening assessment tools is up to the physician, the plan suggests the following:

- PRAPARE (Protocol for Responding to and Assessing the Patients' Assets, Risks, and Experiences)
- CMS Accountable Health Communities Health-Related Social Needs (AHC HRSN)

Role of the PCP

- Each Medicaid and Florida Healthy Kids member will select or be assigned a PCP at the time of enrollment. Medicaid membership is limited to 1,500 members per full-time PCP and may be increased by 750 members for each advanced registered nurse practitioner (ARNP) or physician assistant (PA) affiliated with the physician. The maximum is a 3,000 active patient load for all populations (including but not limited to Medicaid FFS, children's medical services, other SMMC plans, and Kidcare/Florida Healthy Kids).
- The PCP coordinates the member's healthcare needs through a comprehensive network of specialty, ancillary, and hospital providers.
- For new members, the provider will contact each new member within 60 days of enrollment to perform an initial health risk assessment:
    - The provider must notify Simply if they are unable to contact the member within the 90-day enrollment period. Simply will send a release form to Medicaid members for the purpose of Simply and state agency review. Once a release has been signed, the PCP will request records from previous care providers. The PCP will use the previous medical records and the health risk assessments to identify members who have not received age-appropriate preventive health screenings (Child Health Check-Ups) for children from birth through 20 years of age, according to the standards established by the American Academy of Pediatrics and endorsed by AHCA. Health screenings for adults will meet Simply standards, including those standards established by the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force. When external regulating agencies impose more stringent health screening standards, the PCP is required to comply with those standards.
- The PCP is responsible 24/7 for providing or arranging all covered services, including prescribing, directing, and obtaining appropriate authorizations of all care for members who have been assigned to the PCP. After-hours coverage consists of an answering service, call forwarding, provider call coverage, or other customary means approved by Simply. The chosen method must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision.
- To the extent necessary, the PCP is responsible for coordinating coverage for members with an alternate Simply network physician. All financial arrangements must be made between the PCP and covering physician. The PCP is also responsible for notifying Simply in writing two weeks prior to their absence, the duration of the absence, and the physician who will be providing the coverage. The covering physician must be a Simply network physician.
- All PCPs must be credentialed by Simply or one of the Simply delegated credentialing entities. All personnel assisting in the provision of healthcare services to members are to be appropriately trained, qualified, and supervised in the care provided.
- PCPs must notify their Provider Relations representative when a new provider joins the practice.
- Anytime a new provider joins a practice and members are directed to the provider that individual must be credentialed with the plan and cannot see members until the credentialing process is completed. Nonemergent services must not be provided by a noncredentialed physician, and such services will not be covered by Simply. The PCP is responsible for the direct training and supervision of medical assistants. Duties of the medical assistant will be strictly limited to those identified in *F.S. Section 458.3485*.
- All PCP facilities must have handicap accessibility, adequate space, supplies, good sanitation, and fire safety procedures in operation.

- The PCP will only collect copays from Florida Healthy Kids members when applicable and permitted under state and federal law. The PCP must not charge any member for missed appointments.
- PAs and ARNPs may not be assigned as the PCP for Simply members.

Physician Extenders

Physician extenders (for example, ARNPs, PAs) must be credentialed prior to seeing Simply members. They must clearly and appropriately identify themselves as an ARNP or PA to the member. Office staff must appropriately refer to and identify physician extenders as ARNPs or PAs.

Home Health Agencies

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.

Background Checks

All Simply providers must have a Level 2 criminal history background screening completed prior to joining the Simply network. This includes the provider's subcontractors or any employees or volunteers of their subcontractors who meet the definition of "direct service provider" to verify that these individuals do not have disqualifying offenses as provided for in *F.S. Section 430.0402* as created and *F.S. Section 435.04*. 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 *F.S. Section 430.0402*.

Abuse, Neglect, and Exploitation

All Simply providers are required to report elder abuse, neglect, and exploitation of vulnerable adults to the statewide Elder Abuse Hotline at **800-96ABUSE (800-962-2873)**.

- Simply direct service providers are also required to complete abuse, neglect, and exploitation training, including training on how to identify victims of human trafficking.
- Per *s.408.812, F.S.*, Simply providers are required to report suspected unlicensed assisted living facilities and adult family care homes to AHCA and Simply.

Abuse, as defined in Chapter 415, F.S., and Chapter 39, F. S., 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:

- Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses or endeavors to obtain or use, a vulnerable adult's funds, assets, or property for the benefit of someone other than the vulnerable adult.
- Knows (or should know) 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.

Identifying Victims of Human Trafficking

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

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)

Poor mental health or abnormal behavior:

- Is fearful, anxious, depressed, submissive, tense, nervous, or 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, has 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're staying/address
- Lack of knowledge of whereabouts and/or of what city they're 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.

Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Healthcare services provided through Simply must be accessible to all members.

Simply is dedicated to arranging access to care for our members. The ability of Simply to provide quality access depends on the accessibility of network providers. Providers are required to adhere to the following access standards:

Service	Access requirement
Emergent or emergency visits	Immediately upon presentation
Urgent care for BH	**Florida Healthy Kids:** • Within 24 hours
Urgent, non-emergency visits, medical health	**MMA/Specialty:** • Within 48 hours of request for services that do not require prior authorization • Within 96 hours of request for services that require prior authorization
Non-urgent medical	**MMA/Specialty:** • Within 30 days of request for a primary care appointment • Within 60 days of request for a pediatric specialist appointment after the appropriate referral is received by the specialist **Florida Healthy Kids:** • Seven calendar days for routine care • Four weeks for well-child visits
Nonurgent, behavioral health	**MMA/Specialty:** • Seven days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment • 14 days for initial outpatient behavioral health treatment **Florida Healthy Kids:** • Seven calendar days for routine care

Providers must also ensure member access to a follow-up appointment within seven days of discharge.

Providers may not use discriminatory practices, such as preference to other insured or private-pay patients, separate waiting rooms, or appointment days.

Simply will routinely (no less than quarterly) monitor adherence to the access care standards, including monitoring PCPs, specialists, and behavioral health providers. We will report results for Medicaid PCPs to AHCA.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephone answered after hours by an answering service that can contact the PCP or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP or another provider designated by the PCP; someone must be available to answer the designated provider's telephone; another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Simply network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are **not** acceptable:

- Only answering the office telephone during office hours
- Only answering the office telephone after hours by a recording that tells members to leave a message
- Answering the office telephone after hours by a recording that directs members to go to an emergency room for any services needed
- Answering the office telephone with an answering machine that does not explain what to do in an emergency (for example, dial 911)
- Returning after hours calls outside of 30 minutes

Member Missed Appointments

Simply members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Simply requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Simply members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. Simply staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP. Please note that the provider agrees not to charge a member for missed appointments.

Noncompliant Simply Members

Simply recognizes that providers may need help in managing noncompliant members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment, and/or making or appearing for appointments, please call Provider Services at **844-405-4296**. Members should be referred to Simply for case management services.

PCP Transfers

To maintain continuity of care, Simply encourages members to remain with their PCP. However, members may request to change their PCP for any reason by contacting Member Services at **844-406-2396**. The member's name will be provided to the PCP on the membership roster.

Members can call to request a PCP change any day of the month. PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

Covering Physicians

During a provider's absence or unavailability, the provider needs to arrange for coverage for their members. The provider will either: 1) make arrangements with one or more network providers to provide care for their members, or 2) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. Covering providers must have an active limited or fully enrolled Medicaid ID number.

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including, without limitation, any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

Specialist as a PCP

Under certain circumstances, when a member requires the regular care of the specialist, a specialist may be approved by Simply to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist PCP. This would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis.

The specialist must meet the requirements for PCP participation, including contractual obligations and credentialing; provide access to care 24 hours a day, 7 days a week; and coordinate the member's healthcare, including preventive care. When such a need is identified, the member or specialist must contact Simply Member Services and complete a *Specialist as* PCP Request Form. A Simply case manager will review the request and submit it to the Simply medical director. Simply will notify the member and the provider of its determination in writing within 30 days of receiving the request. Should Simply deny the request, Simply will provide written notification to the member and provider outlining the reason(s) for the denial of the request within one day of the decision. Specialists serving as PCPs will continue to be paid fee-for-service while serving as the member's PCP. The designation cannot be retroactive.

Note: Simply allows Infectious Disease providers to serve as a PCPs for HIV/AIDS plan members.

Specialty Referrals

To reduce the administrative burden on the provider's office staff, Simply has established procedures that are designed to permit a member with a condition that requires ongoing care from a specialist physician or other healthcare provider to request an extended authorization.

The provider can request an extended authorization by contacting the member's PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP to complete the authorization review.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract with the treating provider, the continuity-of-care provisions in the provider's contract with Simply will apply. The provider may renew the authorization by submitting a new request to the PCP. Additionally, Simply requires the specialist physician or other healthcare provider to provide regular updates to the member's PCP (unless acting also as the designated PCP for the member). Should the need arise for a secondary referral, the specialist physician or other healthcare provider must contact Simply for a coverage determination.

If the specialist or other healthcare provider needed to provide ongoing care for a specific condition is not available in the Simply network, the referring physician will request authorization from Simply for services outside the network. Access will be approved to a qualified non-network healthcare provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

If a provider's application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through the Simply medical appeal process.

Providers may contact case management to facilitate referrals to services outside our network or services provided through interagency agreements. The case manager will assist as needed to meet the member's additional supportive care needs, such as food, bank, legal, or housing assistance; support groups/psychosocial counseling; clinical trials; and outpatient substance use-related programs geared towards the issues and concerns of our members.

Second Opinions

A member, parent, and/or legally appointed representative or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion will be provided at no cost to the member.

The second opinion must be obtained from a network provider (see the provider referral directory) or with precertification from a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Simply may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we'll make the necessary arrangements for the appointment, payment, and reporting. Simply will inform the member and the PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

Specialty Care Providers

To participate in our programs, providers must be enrolled in Florida Medicaid and have an active limited or fully enrolled Medicaid ID number. Providers must also be a licensed provider by the state before signing a contract with Simply.

Simply contracts with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing specialized care for members, usually upon appropriate referral from a PCP within the network (see **Role and Responsibility of the Specialty Care Provider**). In addition to sharing many of the same responsibilities as the PCP (see **Responsibilities of the PCP**), the specialty care provider provides services that includes but is not limited to the following:

- Allergy and immunology services
- Burn services
- Community behavioral health (for example, mental health and substance use) services
- Cardiology services
- Clinical nurse specialists, psychologists, and clinical social workers (that is, behavioral health)
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Perinatal services
- Pediatric services
- Psychiatry (adult) assessment services
- Psychiatry (child and adolescent) assessment services
- Trauma services
- Urology services

Role and Responsibility of the Specialty Care Provider

Members may self-refer to a participating specialist provider, including mental health and substance use providers. Obligations of the specialist include, but are not limited to the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all Simply members who self-refer or are directed to the specialist provider for care
- Submitting required claims information
- Arranging for coverage with network providers while off duty- or on vacation
- Verifying member eligibility and precertification of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis, following a referral or routinely scheduled consultative visit
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure
- Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance use disorders
- Making provisions to communicate in the language or fashion primarily used by their members

The specialist will:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers, including those engaged on a Fee-For-Service (FFS) basis; provide coordination necessary for referrals to other specialists and FFS providers (both in- and out-of-network); and maintain a medical record of all services rendered by the specialist and other providers.
- Provide 24/7 coverage and maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally in a culturally competent manner and meet the unique needs of members with special healthcare requirements.
- Participate in the systems established by Simply that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Participate and cooperate with Simply in any reasonable internal or external quality assurance, utilization review, continuing education, or other similar programs established by Simply.
- Make reasonable efforts to communicate, coordinate, and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to members.
- Participate in and cooperate with the Simply complaint and grievance processes and procedures; Simply will notify the specialist of any member grievance brought against the specialist.
- Not balance bill members.
- Continue care in progress during and after termination of their contract for up to 60 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with OSHA standards.
- Make best efforts to fulfill the obligations under the ADA applicable to their practice location.
- Support, cooperate, and comply with the Simply Quality Management Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform Simply if a member objects for religious reasons to the provision of any counseling, treatment, or referral services.

- Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis and give members the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program, and advise members on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy or procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care.

Specialty Care Providers Access and Availability

Simply will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if they have a provider agreement with Simply to provide specialty services to members. For more information on our access and availability guidelines, refer to the **Access and Availability** section.

Open-Access Specialist Providers

Members may self-refer to the network providers listed below without a PCP referral. Providers should establish processes for the identification of the member's PCP and forward information concerning the member's evaluation and treatment to the PCP after obtaining consent from the member as appropriate under legal requirements:

- Chiropractors
- Podiatrists
- Dermatologists
- OB/GYN

Professional and Respectful Communication Standards

Simply maintains an ongoing commitment to fostering a respectful, collaborative, and professional environment, recognizing that effective communication is an integral component. Your Participating Provider Agreement (the "Agreement") with Simply outlines your obligations as a participating provider with Simply regarding conduct and professionalism. Providers, including those who represent them, such as office staff, billing entities, are expected to conduct themselves in a professional and respectful manner in all interactions with Simply members, employees, and representatives. Professional and respectful communication is not just a courtesy, but a fundamental responsibility that supports collaboration, builds trust, and enhances the quality of service we offer to our members. By upholding these standards, Providers contribute to a positive and inclusive atmosphere where every individual feels valued and respected.

In addition to the standard policies and guidelines outlined in this manual and your participating Provider Agreement, Simply maintains a zero-tolerance policy for abusive or disruptive behavior, whether physical or verbal, from Providers or those representing Providers during the course of business. Violent acts and/or continued abusive or disruptive behavior will result in the termination of your participation in Simply's provider network.

Examples of behavior that will not be tolerated include, but are not limited to, any act of violence, threats, harassment, intimidation, and other disruptive behavior. Such behavior can include actual physical injury, direct or indirect verbal or written statements, disruptive behavior, suggestions of self-harm, threats of retaliation to others, or gestures that communicate a threat of physical harm.

Restrictions on AI use in Performing a Health Plan Function

Providers who have been delegated to perform a health plan function (for example, Utilization Management, credentialing and/or claims payment) shall not use AI in the performance of any delegated health plan function without the advance written consent of the health plan. Providers shall request such approval in accordance with the notice provisions of the provider agreement, and the health plan shall provide its written response in accordance with the notice provisions of the provider agreement."

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, and 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

When it comes to marketing, you need to be aware of and comply with the following:

- Providers are permitted to make available and/or distribute Simply-approved 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 permitted to display posters or other materials in common areas such as the provider's waiting room. Marketing may not be conducted in areas where patients primarily intend to receive healthcare services or are waiting to receive healthcare services.
- Long-term care facilities are permitted to provide materials in admission packets announcing all managed care plan contractual relationships.

We will provide education, outreach, and monitoring to ensure you are aware of and comply with the following:

- 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 the managed care plan.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the managed care plan for marketing activities.
- Distribute marketing materials within an exam room setting.
- Furnish the managed care plan with lists of their Medicaid patients or the membership of any 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.
  - 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 affiliation information
  - Providers may announce new or continuing affiliations with the managed care plan through general advertising (for example, radio, television, websites).
  - Providers may make new affiliation announcements within the first 30 calendar days of the new provider agreement.
  - Providers may make one announcement to patients of a new affiliation that names only the managed care plan when such 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 contracts.
  - Any affiliation communication materials that include managed care plan-specific information (for example, benefits, formularies) must be prior approved by the Agency.

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 identification number, date of birth, gender, and legal guardianship or responsible party if applicable

- Include information relating to the enrollee's use of tobacco, alcohol, and drugs/substances
- 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
- Include all services provided (this includes but is not limited to family planning services, preventive services, and services for the treatment of sexually transmitted diseases)
- 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; 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, laboratory, 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
- Documentation of the express written and informed consent of the enrollee's authorized representative prescriptions for psychotropic medication (in other words, antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years
- Documentation of the child's consent and proof that a signed attestation has been provided to the pharmacy
- 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 the health plan nor any of its providers can require, as a condition of treatment, the member to execute or waive an advance directive. The health plan must maintain written policies and procedures for advance directives.
- Maintain copies of any advance directives executed by the member
- Enter in the patient's clinical record and appropriately sign or initial significant medical advice given to a patient by telephone or online, including medical advice provided after hours
- 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 non-research-related care

- Review and incorporate into the record in a timely manner all reports, histories, physicals, progress notes, and other patient information such as laboratory reports, X-ray readings, operative reports, and consultations
- 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 ages 12 and older (abbreviations and symbols may be appropriate)
- Provide health education to the member
- Screen patients for substance use and document in the medical record 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 must also be met regarding the patient's medical records:

1. **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 with patient or responsible party (adult).
2. **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.
3. **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 prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.
4. **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.
5. **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.
6. **Release of information** — Written procedures are required for releasing information and obtaining consent for treatment.
7. **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.
8. **Multidisciplinary teams** — Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
9. **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 which 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.

10. **Domestic violence** — Documentation of screening and referral to the applicable community agencies is required.
11. **Consent for psychotherapeutic medications** — Pursuant to *F.S. 409.912(13)*, providers must document informed consent from the parent or legal guardian of members younger than age 13 who are prescribed psychotherapeutic medications and must provide the pharmacy with a signed attestation of this documentation. Pharmacies are required to obtain and keep these consents on file prior to filing a psychotherapeutic medication.
12. **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. Simply will institute actions, including corrective actions for improvement, when standards are not met.

Patient Visit Data

At a minimum, documentation of individual encounters must provide adequate evidence of the following:

1. Date of service; name, signature, and profession (for example, MD, OD, RN) of the person(s) providing the service; type of service provided; department of facility (if applicable); chief complaint; changes in medications with name and dosage; disposition; recommendations or instructions provided; and documentation of missed or cancelled appointments
2. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints
3. For patients receiving behavioral health treatment:
    - Documentation that includes at-risk factors such as danger to self and/or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health concerns.
    - A documented assessment that is done with each visit relating to client status/symptoms and that may indicate initial symptoms of the behavioral health condition as decreased, increased, or unchanged during the treatment period, along with the type and units of service provided.
    - A treatment plan that includes the member and/or parent or guardian's preferences for treatment, identifies reasonable and appropriate objectives, provides the necessary services to meet the objectives, and includes a retrospective review to confirm that care provided and its outcomes were consistent with the approved treatment and member's needs.
    - Documented therapies and other prescribed regimens, and show evidence of family involvement as applicable, and include evidence that the family was included in therapy sessions when appropriate.
4. An admission or initial assessment that includes current support systems or lack of support systems
5. A plan of treatment that includes activities/therapies to be carried out and goals to be met
6. Diagnostic tests
7. For follow-up care encounter forms or notes with a notation indicating follow-up care, a call or a visit that must note in weeks, months, or PRN (as needed) the specific time to return with unresolved problems from any previous visits being addressed in subsequent visits
8. Referrals and results, including all other aspects of patient care, such as ancillary services

Simply will systematically review medical records to ensure compliance with these standards. We will share the results of our audits and institute actions for improvement when standards are not met.

We maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in accordance with the record retention requirements of *45 CFR 438.3110*, which states that records must be retained for ten years from the date of termination of Simply's SMMC contract with AHCA and retained further if records are under review or audit until the audit or review is complete. Prior approval from Simply is required for the disposition of records if subcontract is continuous, per *438.4.u*.

Misrouted Protected Health Information

Providers and facilities are required to review all member information received from Simply to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be inadvertently misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to immediately notify Simply upon receipt of the information, not forward or copy the documents, and destroy the misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, they should call Provider Services at **844-405-4296** for help.

Advance Directives

Simply respects the right of the member to control decisions relating to their own medical care, including the decision to have provided, withheld, or withdrawn the medical or surgical means or procedures calculated to prolong their life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

Simply adheres to the Patient Self-Determination Act and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to healthcare providers about treatment choices in certain circumstances. There are two types of advance directives. A durable power of attorney for healthcare (that is, durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state their wishes in writing, but does not name a patient advocate.

Member Services and Outreach associates encourage members to request an advance directive form and education from their PCP at their first appointment.

Members over age 18 and emancipated minors are able to make an advance directive. Their response is to be documented in the medical record. Simply will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive. Member Services and Outreach associates will assist members regarding questions about advance directives; however, no Simply associate may serve as witness to an advance directive or as a member's designated agent or representative.

Simply notes the presence of advance directives in the medical records when conducting medical chart audits.

Telemedicine

Florida defines telemedicine as the practice of healthcare delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment (59G-1.057, F.A.C.).

If we approve you to provide services through telemedicine as exhibited in your Participating Provider Agreement or Amendment, 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.

When providing services through telemedicine:

- The telecommunication equipment and telemedicine operations must meet the technical safeguards required by *45 CFR 164.312*, and Rule 59G-1.057 F.A.C. where applicable.

We educate the patient, obtain consent, document the choice for telemedicine in the patient's medical record, and include detailed notes from each visit.

You must comply with *HIPAA* and other state and federal laws pertaining to patient privacy.

.

8 MEDICAL MANAGEMENT

Medical Review Criteria

Simply has its own nationally recognized medical policy process. Simply medical policies, which are publicly accessible on the subsidiary websites, are the primary benefit plan policies for determining whether services are considered to be 1) investigational/experimental, 2) medically necessary, and 3) cosmetic or reconstructive.

A list of the specific *Clinical Utilization Management Guidelines* used is posted and maintained on the Simply provider website and can be obtained in hard copy by written request. Providers can also contact Provider Services at **844-405-4296** for more information. These policies will support precertification requirements, clinical appropriateness claims edits, and retrospective review.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede Simply medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and clinical utilization management criteria.

Simply uses MCG care guidelines for inpatient concurrent reviews except for those hospitals where the contract states differently. Unless superseded by state Medicaid or CMS requirements, all nonbehavioral health, behavioral health outpatient precertification requests, and behavioral health concurrent reviews will be determined using Simply *Medical Policies* and Clinical Utilization Management Guidelines.

We work with network providers to develop clinical guidelines of care for our membership. The medical advisory committee assists us in formalizing and monitoring guidelines.

If we use noncommercial criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of market practice and national standards/best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated, as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development, and when and how often the criteria will be evaluated and updated.

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 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 electronic, faxed, or telephonic 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.

Utilization Management Decision Making

Simply, as a corporation and as individuals involved in utilization management (UM) decisions, are governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Simply does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

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 at **844-405-4296**. Staff are available Monday to Friday, 8 a.m. to 7 p.m. ET (excluding state holidays) to assist with inquiries and problems related to the provision of services and claims. The helpline is additionally staffed after hours to respond to authorization requests.
- Staff can receive inbound communication regarding UM issues after normal business hours at **844-405-4296**. Our after-hours answering service will ensure providers can leave a message for 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 **844-405-4296**.

Preventive Care Guidelines

Simply uses nationally recognized preventive care, evidence-based clinical practice information, guidelines, and protocols. This information is on the provider website to ensure fair, consistent, and quality healthcare services and treatments are provided to members. Our clinical practice and preventive care guidelines can be found on the provider website under Medical Policies and Clinical UM Guidelines at **provider.simplyhealthcareplans.com/florida-provider/manuals-and-guides**.

The following are links to the HIV/AIDS-specific guidelines:

Guideline	Hyperlink	Agency
Adult HIV	**HIV/AIDS Treatment Guidelines | Clinicalinfo.HIV.gov**	U.S. Dept. of Health and Human Services, Clin. Guidelines updated: September 21, 2022
Primary Care Guidelines for the Management of Persons Infected with HIV	**Correction to: Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America | Clinical Infectious Diseases | Oxford Academic**	2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America
Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents	**clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/whats-new-guidelines**	National Institutes of Health, AIDS Information updated May 2, 2024

The following are links to the SMI-specific guidelines:

Guideline	Hyperlink	Agency
Roadmap for Behavioral Health Integration	**hhs.gov/about/news/2022/12/02/hhs-roadmap-for-behavioral-health-integration-fact-sheet.html**	U.S. Department of Health and Human Services
Guidelines for Treatment	**psychiatry.org/psychiatrists/practice/clinical-practice-guidelines**	American Psychiatric Association Clinical Practice Guidelines
Behavioral Health Crisis Intervention Toolkit	**samhsa.gov/mental-health/national-behavioral-health-crisis-care**	SAMHSA National Guidelines for Behavioral Health Crisis Care
PCP Clinical Practice Guidelines and Recommendations	**aafp.org/family-physician/patient-care/clinical-recommendations/clinical-practice-guidelines/clinical-practice-guidelines.html**	American Academy of Family Physicians Clinical Guidance and Practice Resources

Treatment adherence services are available through Simply for all plans including specialty products. Case managers communicate the information to members, and information is made available to all PCPs.

Clinical Practice Guidelines

Clinical practice guidelines are resources to assist with the management of chronic medical conditions for the care of our membership. The medical advisory committee (MAC) oversees and directs Simply in adopting and monitoring guidelines. We must review and revise the guidelines at least every two years or whenever the guidelines change.

The clinical criteria are guidelines developed by industry specialty associations and organizations, including but not limited to:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Family Physicians
- American Academy of Pediatrics
- American Cancer Society
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians
- American Diabetes Association
- American Lung Association
- American Medical Association
- Centers for Disease Control and Prevention
- Department of Health and Human Services Commission
- National Institutes of Health
- U.S. Preventive Services Task Force

Visit our provider website under Medical Policies and Clinical UM Guidelines to review and download a copy of the clinical practice guidelines: **provider.simplyhealthcareplans.com/florida-provider/manuals-and-guides**. You may also call Provider Services at **844-405-4296** to request a hard copy, and we will gladly mail it to you.

Clinical Criteria

The criteria provide a system for screening proposed medical care based on member specific best medical care practices and rule-based systems to match appropriate services to member needs based upon clinical appropriateness. Criteria include:

- Acute care (adult and pediatric)
- Rehabilitation
- Subacute care
- Home care
- Surgery and procedures
- Imaging studies and X-rays

Simply utilization reviewers use these criteria as part of the precertification of scheduled admission, concurrent review, and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization. These criteria are reviewed at least annually.

Simply is available 24/7 to accept precertification requests. When a request is received from the physician via telephone, online submission, or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse. The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the physician in identifying alternatives for healthcare delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with our *Clinical UM Guidelines* criteria, a Simply reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history. Decisions on urgent requests (that is, expedited service authorizations) will be made within two calendar days.

Simply requires all expedited (urgent) service authorization requests be submitted via the Availity Essentials Authorization application at **Essentials.Availity.com**. From the Availity Essentials home page, select Patient Registration > Authorizations & Referrals > Authorization Request and follow the navigation steps to submit an authorization. This will allow us to prioritize urgent service authorization requests appropriately, improve turnaround times, and reduce errors. Please do not send expedited (urgent) service authorization requests via fax or phone call. All expedited requests must meet the following criteria: *42 CFR 438. 210(d)(2)(i)* states the following regarding expedited request for authorization: "For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service."

If medical necessity criteria for the admission are not met on the initial review, the medical director will contact the requesting physician upon request to discuss the case.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. Two requests for additional information will be made over a 48-hour period. If information is not received within the specified time, the request will be denied. If the medical director denies coverage of the request, the appropriate denial letter (including the member's appeal rights) will be mailed to the requesting provider, the member's PCP, and the member.

If the medical director denies the request for coverage, the appropriate notice of proposed action will be mailed to the requesting provider, the member's PCP, the facility, and the member.

The preferred method for submitting preauthorization requests and required for any expedited requests is through the digital authorization application accessed through Availity Essentials at **Essentials.Availity.com**. From the Availity Essential home page, select Patient Registration > Authorizations & Referrals > Authorization Request and follow the navigation steps to submit an authorization. Digital authorizations offer a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for our members. Additionally, providers can use the application to make inquiries and check on the status of previously submitted requests, regardless of how they were sent (phone, fax, or other online tool).

Capabilities and benefits of using the authorization application include:

- Initiating preauthorization requests online — eliminating the need to fax. The authorization application allows detailed text, photo images, and attachments to be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, or other online tool.
- Having instant accessibility from almost anywhere, including after business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates, including email notifications if requested using a valid email address.
- Viewing real-time results for common procedures with immediate decisions.
- Requesting and checking the status of clinical appeals for denied authorizations.
- Viewing letters affiliated with the case.
- Submitting an appeal for a UM denial

You can access the authorization application through Availity Essentials. From the Availity Essentials home page, select Patient Registration > Authorizations and Referrals. For an optimal experience, use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome, and Firefox.

The authorization application is not currently available for:

- Transplant services.
- Services administered by vendors, such as Carelon Medical Benefits Management and Health Network One (HN1). For these requests, follow the same preauthorization process you use today.

We'll update our website as additional functionality is added throughout the year.

Hospital and Elective Admission Management

Simply requires precertification of all inpatient elective admissions. The referring primary care provider (PCP) or specialist physician is responsible for precertification. The referring physician identifies the need to schedule a hospital admission and must submit the request to the Simply Medical Management department.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Simply to verify benefits and process the precertification request. For services that require precertification, Simply makes case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with medical necessity criteria.

The hospital can confirm that an authorization is on file by calling the Simply Provider Services automated system at **844-405-4296** or accessing our secure website. If coverage of an admission has not been approved, the facility should call Simply at **844-405-4296**.

Emergent Admission Notification Requirements
Simply prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Simply of emergent admissions within one business day. Simply Medical Management staff will verify eligibility and determine benefit coverage. No prior authorization is required for emergency admissions.

Simply is available 24/7 to accept emergent admission notification via the authorization application accessed through Availity Essentials at **Essentials.Availity.com** or **844-405-4296**.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets the criteria, a Simply reference number will be issued to the hospital. Two requests for clinical information will be made over a 48-hour period if clinical information was not provided with notification. If information is not received within 72 hours of the initial request, the request will be denied. If the notification documentation provided is incomplete or inadequate, Simply will not approve coverage of the request and will notify the hospital to submit the additional necessary documentation. If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the hospital, member's PCP, and the member.

Nonemergent Outpatient and Ancillary Services: Precertification and Notification Requirements

Simply requires precertification for coverage of selected nonemergent outpatient and ancillary services. To ensure timeliness of the authorization, the expectation is for the facility and/or provider to provide the following:

- Member name, DOB, and ID
- Name, phone, and fax number, TIN (*or* NPI and address) of the physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member ICD-10 diagnosis
- Name of elective procedure to be performed with CPT code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans, and medications)

For more information on prior authorization and notification requirements, refer to the **Simply Healthcare Benefits and Copays** and our provider website.

Inpatient Reviews

Inpatient Admission Review
We'll review all inpatient hospital admissions, including urgent and emergent admissions, within 24 hours of admission notification. The Simply utilization review clinician determines the member's medical status through communication with the hospital's utilization review department. Appropriateness of stay is documented, and concurrent review is initiated. Cases may be referred to the medical director, who renders a decision on the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination by the Care Management program.

Inpatient Concurrent Review
Each network hospital will have an assigned Utilization Management (UM) nurse. Each UM nurse will conduct a utilization review of the hospital medical record using EMR or phone/fax review to determine the authorization of coverage for a continued stay.

When a Simply UM nurse reviews the medical record, they work closely with the hospital case management team and contacts the member or member representative as needed to discuss any discharge planning needs

and verify that the member or family is aware of the PCP's name, address and telephone number. The UM nurse will conduct continued stay reviews and review discharge plan needs.

When the clinical information received meets medical necessity criteria, approved continued stay days will be communicated to the hospital. The request for the clinical information needed will be communicated to the designated department within the hospital. Simply asks that the hospital reviewer provide only the necessary information being requested.

Upon discharge Simply UM clinician will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The attending physician is expected to coordinate with the member's PCP regarding follow-up care after discharge. The PCP is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health discharge, the attending physician is responsible for ensuring the member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

Simply will authorize covered length of stay one day at a time based on the clinical information that supports the continued stay. Exceptions to the one-day length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days or is predetermined by state law. Examples of confinement and/or treatment include the following: ICU, CCU, behavioral health rehabilitation, and C-section or vaginal deliveries. Exceptions are made by the medical director.

If the medical director denies coverage for an inpatient stay request based on appropriate criteria and after offering a peer-to-peer discussion, the appropriate notice of action will be mailed to the hospital, the member's PCP, and the member.

Discharge Planning

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (that is, hospitalization) is no longer necessary.

When long-term care is necessary, Simply works with the provider to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility, such as:

- A hospice facility
- A convalescent facility
- A home health care program (for example, home IV antibiotics)

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations follow Simply *Clinical UM Guidelines*. Authorizations include, but are not limited to, home health, durable medical equipment, pharmacy, follow-up visits to practitioners, or outpatient procedures.

Confidentiality of Information

Utilization Management (UM), case management, condition care, discharge planning, quality management, and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is used for the purposes defined above. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct UM and related processes.

Emergency Services

Simply provides a 24/7 NurseLine 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.

Simply does 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 that are 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) place 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.

Emergency response is coordinated 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. Simply 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.

Urgent Care

Simply requires its members to contact their PCP in situations where urgent, unscheduled care is necessary. Precertification with Simply is not required for a member to access a participating urgent care center.

Community Mental Health Centers (CMHC) and Certified Community Behavioral Health Clinics (CCBHC) Coordination Protocols

To ensure appropriate and comprehensive treatment planning that addresses the enrollee's medical and behavioral health needs, our case managers work in collaboration with our members and our CMHCs and CCBHCs to coordinate integrated care in their area. These providers have a comprehensive array of services, including evidence-based practices and 24-hour crisis care.

9 QUALITY MANAGEMENT

Quality Management Program

Overview

Simply maintains a comprehensive Quality Management (QM) program to objectively monitor and systematically evaluate access to care and the quality and appropriateness of care and services rendered, to promote quality of care and patient outcomes (see *42 CFR 438.340* and *438.330*). The scope and content of the program reflects the demographic and epidemiological needs of the population served. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

Members and providers have opportunities to make recommendations for areas of improvement. The QM program goals and outcomes are available, upon request, to providers and members. The easiest way for providers to access this information is by going to the provider website, and members can go to the member website.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan's specific population occurs on an annual basis. This includes not only age and gender distribution, but also a review of utilization data — inpatient; emergent/urgent care; and office visits by type, cost, and volume. This information is used to define areas that are high-volume or problem-prone.

There is a comprehensive committee structure in place with oversight from the Simply governing body. Not only are the traditional Medical Advisory Committee (MAC), Peer Review Committee (PRC), and Credentialing committee in place, but a community/enrollee advisory committee are also integral components of the quality management committee (QMC) structure.

Quality of Care

All physicians, advanced registered nurse practitioners and physician assistants are evaluated for compliance with pre-established standards as described in the Simply credentialing program.

Review standards are based on medical community standards, external regulatory and accrediting agencies requirements, and contractual compliance.

Reviews are accomplished by Florida licensed nurses and associate professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members.

Results are submitted to the Simply QM department and incorporated into a profile.

The Simply quality program includes review of quality-of-care issues identified for all care settings. QM staff use peer review, performance improvement projects (PIP), medical/case record audits, performance measures, surveys, member complaints, and other information to evaluate the quality of service and care provided to our members. In addition, Simply reviews and analyzes adverse or critical incidents to identify and work to eliminate potential and actual quality of care and/or health and safety issues.

Overview of CAHPS®

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Simply's members about their experiences with Simply in the past year. This includes the member's access to medical care and the quality of the services provided by Simply's network of providers. Simply analyzes this feedback to identify issues causing members dissatisfaction and

works to develop effective interventions to address them. Simply takes this survey feedback very seriously.

Health Plans report survey results to National Committee for Quality Assurance (NCQA), which uses these survey results for the annual accreditation status determinations and to create National benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.
Results of these surveys are shared with providers annually, so they have an opportunity to learn how Simply members feel about the services provided. Simply encourages providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Patient Safety at Simply
Simply's mission is improving lives and communities. Patient safety is an important component in this mission. Simply strives and reinforces efforts to build a safer, equitable high quality healthcare system; decrease the occurrence of patient safety events, potentially preventable conditions (PPCs) and hospital acquired and healthcare acquired conditions (both referred to as HACs); and ensure compliance with Federal and State regulatory requirements and BCBSA contractual requirements. We advocate for a safety culture that improves the delivery of healthcare, health outcomes, and alignment with national patient safety efforts. In doing so, we are committed to working with physicians, hospitals, and other healthcare partners.

Patient safety activities are designed to promote safe practices by identifying opportunities for improvement and refining processes throughout the healthcare delivery system, including as it applies to health disparities. We advocate for safe clinical care and services; collaborate and engage with medical and behavioral health providers, as well as members, concerning patient safety; and identify opportunities for system and process improvements that promote patient safety within individual practices and across the healthcare continuum.

We select areas of focus and monitoring by analyzing patient safety for members inherent to the quality of medical and behavioral healthcare delivery and services as it applies to Population Health Management programs that targets keeping members healthy; managing members with both emerging risk and with chronic illnesses; enhancing health equity by addressing disparities; and patient safety or outcomes across healthcare settings.

Our goal is to support physicians and hospitals in using appropriate processes, technologies, and strategies to address never events and healthcare acquired conditions, and, ultimately, to enhance the quality of care delivered to patients. Simply strives to eliminate inpatient PPCs and HACs as defined by the Centers for Medicare and Medicaid Services (CMS), remaining consistent with CMS payment policy and as stated in Simply's reimbursement policy/contracts. Reimbursement policies may be superseded by mandates in provider, state, federal or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements.

Use of Performance Data
Practitioners and providers must allow Simply to use performance data in cooperation with our quality improvement program and activities.

Quality Management Committee

The purpose of the QMC is to maintain quality as a cornerstone of Simply culture and to be an instrument of change through demonstrable improvement in care and service. The QMC's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the QM program.
- Establish processes and structure that ensure accreditation compliance.
- Review and policies and procedures as appropriate.
- Analyze, review, and make recommendations regarding the planning, implementation, measurement, and outcomes of clinical/service quality improvement studies.
- Address and resolve any problems/issues identified but not included in a process improvement program.
- Coordinate communication of QM activities throughout the health plans.
- Review and analyze HEDIS® and CAHPS® data and develop action plans for improvement.
- Review, monitor, and evaluate program compliance against Simply, state, federal, and accreditation standards.
- Review and approve the annual QM Program Description and work plan.
- Provide oversight and review of operational indicators.
- Assure interdepartmental collaboration, coordination, and communication of quality improvement activities.
- Measure compliance to medical and behavioral health practice guidelines.
- Monitor continuity of care between medical and behavioral health services.
- Promote cultural competency.
- Make information publicly available to members and practitioners about actions to improve patient safety.
- Make information available about the quality improvement program to members and practitioners; members and providers can request the program by calling Customer Service.
- Assure practitioner involvement through direct input from our MAC or other mechanisms that allow practitioner involvement.
- Provide communication to and from the BOD regarding strategic direction for the QM plan.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Medical Advisory Committee (MAC)

The MAC has multiple purposes. It:

- Assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care.
- Monitors practice patterns to identify appropriateness of care and for improvement/risk prevention activities.
- Identifies opportunities to improve services and clinical performance by establishing, reviewing, and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk, and problem-prone conditions.
- Oversees the peer review process, which provides a systematic approach for the monitoring of quality and the appropriateness of care.
- Advises health plan administration in any aspect of health plan policy or operation affecting network providers or members.
- Approves and provides oversight of the peer review process, the QM program, and the utilization review program.

The MAC's responsibilities are to:

- Use an ongoing peer review system to assess levels of care and quality of care provided.
- Monitor practice patterns to identify risk prevention activities and the appropriateness of care.
- Review, provide input, and approve evidence-based clinical protocols and guidelines to facilitate the delivery of quality care and appropriate resource utilization.
- Review clinical study designs and results.
- Develop and approve action plans and recommendations regarding clinical quality improvement studies.
- Review, provide input for, and approve policies and procedures for, QM, utilization management and disease/case management.
- Review and provide feedback regarding new technologies.
- Oversee the compliance of delegated services.
- Review and provide input to clinically oriented quality management policies and procedures, utilization management policies and procedures, and disease/case management policies and procedures.
- Review and provide feedback regarding new technologies.
- Oversee compliance of delegated services.

Peer Review Committee (PRC)

Purpose

As a subcommittee of the QMC, the goal of the Peer Review Committee is to continually improve the quality of care and service provided to members and to ensure that care is consistent with appropriate medical practice standards.

Responsibilities

The PRC is responsible for:

- Evaluating the appropriateness of care rendered by the plan's contracted providers.
- Reviewing provider's practice methods and patterns.
- Evaluating provider performance, trends in quality of care, and service issues.
- Developing and analyzing plan wide audits.
- It may also serve as the plan's provider advisory council providing input and recommendations to the plan concerning, but not limited to, the clinical guidelines adopted, QM Trilogy documents, Credentialing report, PIPS, process improvements, quality indicators, performance measures, and HEDIS.

Maternal Mortality Review Committee (MMRC)

Purpose

A subcommittee of the MAC that is focused on identifying factors impacting maternal morbidity and mortality among members and across the state.

The MMRC is responsible for:

- Reviewing statewide maternal morbidity and mortality data.
- Identifying contributing factors, gaps in care, and disparities.
- Evaluating existing programs and resources.
- Developing new programs and interventions to reduce maternal mortality and improve birth outcomes.

Provider Orientation and Education

The QM team includes clinical quality managers and nurses knowledgeable about quality standards and HEDIS performance measures. The QM team is available for targeted quality focused meetings with providers to educate and support the provider team. QM staff completes an annual medical record review with a sample of providers and is available to furnish providers with a thorough explanation of review findings during an exit conference. Providers who would like QM support are encouraged to communicate that need to their representative.

Medical Record Documentation Review Standards

This applies to the Medicaid programs for Simply Healthcare Plans, Inc. (Simply), Serious Mental Illness, and the Florida Healthy Kids (FHK) program for Simply.

The organization requires practitioners and providers health records to be shared and maintained in a manner that is current, detailed and organized to facilitate communication and coordination of care. The organization establishes health record standards by ensuring that practitioners and providers in its network comply with the standards. The organization distributes the health record standards to all practitioners and appropriate staff members who handle medical records, including organization staff and any staff in the medical practitioner's office.

Confidentiality of medical records

- Records are stored securely.
- Only authorized personnel have access to records.
- Staff receive periodic training in member information confidentiality.

Administrative Component (A)	
Element	**Standard**
Record is organized, legible, and easily accessible to the healthcare practitioners and personnel	Records are fastened with contents organized in a logical, consistent manner to facilitate information retrieval. There is individual record for each member. The record must be legible.
Security measures in place to protect medical records, such as controlled access to electronic systems and secure file storage for paper records.	As described
All entries are complete, dated, and signed by the appropriate healthcare provider.	As described
Staff understand and comply with confidentiality practices, including the appropriate handling and sharing of patient information.	As described
There are written policies for privacy and confidentiality that reference access to PHI and include the process to address members' requests to restrict access, amendments, or disclosures.	As described
Member ID on file	A copy of membership card on file or in the medical record and written office policy to verify member eligibility before rendering service.

Administrative Component (A)	
Element	**Standard**
Personal Identifying data (Name, Gender, DOB)	Required information: Name, DOB, sex, address, and telephone number. For pediatric members (under 21 years old) names of parents or legal guardian are required.
Primary language	All records must reflect the member's primary spoken language and translation needs, to include services for the deaf/hearing impaired, as well as evidence of access to a translator. If English is the primary language, this must be documented.
Evidence of access to an interpreter, or translator if evidence of a gap in language communication	As described
Advance Directives advisement	All records member's 18 years and older must contain Document that the member was provided written information concerning Advance Directive.
Copy of Advance Directives	If the patient chose to make an Advance Directive, there should be a copy of it in the MR.
Patient ID on each page	Patient name, first & last, and/or identification number are on **ALL** pages, reports, documents in the record. Pages that are used on both sides require identification on each side.
All entries dates and signed by appropriate party	All entries are signed and dated with month, day, and year. All entries contain author identification and professional status (MD, DO, ARNP, PA) when applicable.
All entries include the name and profession of the provider rendering the services including the signature or initials of the provider	As described
All entries shall include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services.	As described
Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13) years, if applicable (such as PCP prescribing ADHD meds)	As described
Test Accomplished and filed	Process is in place to obtain and follow up on diagnostic studies (in other words, log book, computer log, copies of all diagnostic studies are on file).
F/U on missed/cancelled app	Documentation of follow-up for missed and cancelled app. Is required.

Administrative Component (A)	
Element	**Standard**
Signed *HIPAA* information form	Signed *HIPAA* Privacy Statement Form and placed in the Medical Record.
Telephone or e-mail communication	Significant medical advice or prescriptions given to a patient by phone or online should be entered in the medical record and signed or initialed, including medical advice provided after hours or telephone triage.
Translation or other communication needs	If translation is needed must be documented and included services for the deaf/hearing impaired.
Legal Guardian (if applicable)	As described
No white out or alterations	The Medical Record must not contain any alterations or the use of whiteout for legal purposes. If an error is made, a single line is drawn through the error with "error" written above with initials and date.
Record provided timely for review	All Medical Records will be provided in a timely manner the date of the review if you have not inconvenient.
Retention of active records/retirement of inactive records	As described.
If telemedicine, documentation that the member had a choice of whether to access services through a face-to-face or telemedicine encounter.	If applicable.
Medicaid services	Evidence that the member had a choice of whether to receive Medicaid covered service or an in lieu of service.

Adult Preventive Components (B)	
Element	**Standard**
Complete Medical History for New Members/Complete PE for New Members	• All new members should have a complete Medical History that includes: CC/HIP/PMH/PSxHx/PSocial Hx/Tobacco Hx ETOH/Drugs/ Allergies/ROS, and must be updated when necessary. • All new members should have a complete Physical Exam: Vital Signs/General/HEENT/Chest/Lungs/ Heart/Abdomen Extremities/Skin/GU/Nodes/ Neurology.

Adult Preventive Components (B)	
High Risk Behaviors and Anticipatory Guidance	Screening to identify high risk individuals and documented in the chart. Teaching specific topics. Obtain consent for tests for the clinical findings or referred to appropriate treatment; Tobacco/Cigarette use/ETOH/Substance use/HIV/STD/ Hepatitis Risk/Safe Sex Practices/Nutrition/Injury, Safety prevention/ Violence/Abuse/Social/Emotional Health/Depression/ Activity/Exercise.
Measurement/Vital Signs	Document Vital signs: BP/HR/RR/Wt. /Ht. on each visit. Adult Body Mass Index
Screening	All screening preventive tests must be documented in the MR. • **Cholesterol**: Starting at 20 years, obtained once every 5 years. • **EKG:** Test to be done for patient at high risk. • **Diabetes Screening:** screening is age 35-70 for patients overweight or obese or with other risk factors. • **AAA Screening:** for men 65-75 who smoke, or who do not smoke but have a first degree relative who had a AAA. • **TB:** Skin testing for asymptomatic high-risk patients. • **Osteoporosis Screening/Testing:** screening in women under 65 with risk factors, all women 65 and older, and men with risk factors • **Menopause Screening:** Screening at physician discretion. • **Vision Screening:** Annually. • **Hearing Screening:** Starting at 20 years, obtained once every 10 yr. • **Dental Health Screening**: Annually. • **Chlamydia:** All sexually active females <26 years, as well as other at risk. • **Breast Exam/Mammography:** Annually for ages 40 and older. • **PAP Smear:** Every 3 years • **Colorectal CA Screening:** At 45 both men and women start Colorectal CA screening Colonoscopy/ Sigmoidoscopy every 5 years or at physician discretion. The choice of specific screening strategy should be based on patient preferences (FOBT), medical contraindications, patient adherence, and available resources for testing (FOBT) and follow-up. • **Prostate Exam/PSA:** Annually beginning at age 50.

Adult Preventive Components (B)	
	• **Skin Cancer:** screening in Florida is annual and part of the annual physical • **HIV Testing:** HIV screening is at least once for every adult, annually for persons in high-risk groups, in addition to testing after a high-risk exposure. • **Copy of completed screening Instruments in the enrollee record and proof that a copy has been provided to the enrollee.**

Diabetes Component (C)	
Element	**Standard**
Nutritional Status, Wt. Hx.	Eating pattern, Nutritional status, Check Wt. Hx on each visit.
DKA frequency, Hypoglycemia	Document Diabetes complications, DKA, Low BS
BP at every routine visit	BP at each visit lower 140/90
Dilated eye exam	Dilated retinal exam annually
Thyroid palpation annually	Thyroid palpation or T3-T4-TSH annually
Skin examinations	At every routine visit
Neurology/foot examination	At every routine visit/ annually for neuropathy.
Hb A1C Test	Hb A1C Test every 3 months for abnormal results (>7), every 6 months for normal result (<7).
Liver function test	Liver function test annually.
Micro albuminuria	Micro albuminuria test annually.
Serum creatinine/GFR	A baseline serum creatinine level is indicated for all Diabetes patients.
LDL Control	Fasting lipid profiles are indicated annually. Goals: <100 mg/dL.
Influenza Vaccine	Influenza Vaccine every year.
Pneumococcal Vaccination	The Pneumococcal Vaccine is indicated for all patients with Diabetes. Revaccination every 5 years.
Obesity Management for BMI >24	Medical Nutrition Therapy (MNT) involving a nutritional assessment to evaluate the patient's food intake, metabolic status, lifestyle, readiness to make changes, and goal setting dietary instruction and evaluation.
Education on Nutrition	Document patient Education on Nutrition, Plan should be individualized and take into account cultural, life style and financial considerations. Refer to a Diabetic educator if necessary.

Diabetes Component (C)	
Education on Physical Activity	Encourage Physical Activity. Referrals if needed. Documented.
Weight	Encourage for Weight control. Referrals if needed to a Nutritionist as needed.
Advise all patients not to Smoke	Document and advise all patients not to smoke.
Advise all patients on alcohol consumption	Document and advise all patients on alcohol consumption.
Referrals	Document any Referrals if needed.

General Medical Component (D)	
Element	**Standard**
ASSESSMENT:	
Medical History & Physical Exam	A complete medical**,** psychosocial, and medical-surgical history must be documented in the MR, including a Review of systems. A complete Physical Exam (General, Heart, Lungs, Abdomen, Extremities, HEENT, Neck, and GU). Include all VS. Updated as needed.
Chief Complain/Subjective	Describe the symptom, problem, condition, or other factor that is the reason for a medical encounter.
Past Medical History	Should contain the total sum of a patient's health status prior to the presenting problem and must include: Past illnesses, Hospitalizations, Injuries, Surgeries, Blood Transfusions.
Past Surgical History	See General Medical Component #1.
Past Social History	These must include: occupational and recreational aspects of the patient's personal life (in other words, Alcohol, Tobacco, Illicit drugs).
Family History	A family history consists of information about disorders from which the direct blood relatives of the patient suffered, (in other words, DM/Cardiovascular disease/Cancer/Autoimmune Disorders).
Blood Transfusion History	See General Medical Component #1.
Health Risk Assessment, if applicable	A Health Risk Assessment is to be completed on all Medicare members and all high-risk members
Allergies/untoward reactions	Allergies or absence of allergies and untoward reactions to drugs and materials recorded in a prominent and consistent location, **verified at each** patient encounters, and updated to reflect new allergies and sensitivities.

General Medical Component (D)	
Element	**Standard**
ASSESSMENT:	
Diagnosis or medical impressions	At the end of each Office Visit you must document a Diagnosis or a Clinical impression that is congruent with H&P and the symptoms/presenting complaint.
Medication list	A medication profile documenting all past, present medications, including those for chronic conditions, over-the-counter products, and dietary supplements. Medications must document dosage, route frequency, and start and stop dates. Documentation of acute medications cannot be documented solely on the progress notes.
Evidence that the needs of the caregiver have been assessed and addressed (if applicable).	As described

General Medical Component (D)	
Element	**Standard**
TREATMENT PLAN:	
Treatment Plan is consistent with diagnosis	The rationale for which a plan is formulated, the diagnostic impression, is required. Appropriateness based on the findings in the History and Physical. Please refer to General Medical Component #9.
The working Dx. are consistent with findings	Addresses each chief complaint (subjective/objective) and clinical finding with a working Diagnosis.
Plan of Care/Studies ordered	Every Office Visit must document: Plan of Care/Studies ordered (if applicable) for the clinical findings and/or diagnosis stated.
Documentation of patient participation in treatment and follow up with recommendations	Evidence of discussion of treatment with the patient and their active participation, or lack thereof.
Absence of clinically unnecessary diagnostic/therapeutic procedures	As described.
Opioid Medications	Opioid Medication prescribed for the treatment of Acute Pain listed in Schedule II-limited to 3-day supply (pain related to cancer, terminal illness, palliative care, and serious traumatic injury are excluded from theses prescribing limits)
Acute Pain Exemption	Pain listed in Schedule II –limited to 7-day supply. (pain related to cancer, terminal illness, palliative care, and serious traumatic injury are excluded from these prescribing limits)
Prescription for Controlled Substance	Controlled substances in Schedule III, IV, V for treatment of acute pain is limited to 14-day supply. Pain related to cancer, terminal illness, palliative care, and serious traumatic injury are excluded from these prescribing limits.

General Medical Component (D)	
Element	**Standard**
PATIENT VISIT/PROGRESS NOTES DOCUMENTATION:	
Date and Department, if department applicable	The complete date and time when services were rendered. If a department is applicable, include the department's name.
Chief Complaint/Purpose of Visit	As described.
Clinical Objective Findings/VS/BMI	Each Office Visit must contain a Complete Objective Finding, including Vital Signs and Body Mass Index, documented in the MR. If BMI is over 29.9 an appropriate diagnosis of Obesity and subsequent treatment documented.
Current review of medications/Reconciliation	Current review of medications (prescription & non-prescription, including over-the-counter and dietary supplements). Medications must document dosage, route frequency, and start and stop dates.
Diagnosis or medical impression	See General Medical Component #9.
Studies ordered	Studies ordered, such as laboratory tests, X-rays studies, were reviewed and incorporated in the record in a timely manner.
Care rendered and therapies administered/prescribed	Addresses therapies administered and prescribed according to clinical findings.
Disposition, recommendations and instructions given to patient	Documentation of case disposition, recommendations and instructions to the patient must be documented in all progress notes.
Authentication and verification of contents by healthcare professional	All documentation is to be authenticated and verified by a healthcare professional.
Documentation regarding missed/cancelled apt.	Documentation of patient cancelations, if applicable.
Signature of healthcare professional.	All progress notes must be signed and dated the day that services were rendered. Signatures should be legible with the name and credentials of the healthcare professional who rendered the services.
Unresolved problems from previous visits are addressed in subsequent visits.	Documentation of follow-up care is present: Unresolved Problems from previous visits are addressed in subsequent visits. Follow up of high-risk issues identified in the history, physical, or at subsequent visits.
Documentation of all services provided if any.	Document in the MR any services provided to the patient (in other words, Family Planning, STD Treatment).
Any notation in the clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.	Documentation of services provided as part of clinical research is clearly identified and contrasted with entries related to non-research care.

General Medical Component (D)	
Element	**Standard**
PATIENT VISIT/PROGRESS NOTES DOCUMENTATION:	
Discussions with the patient concerning the necessity, appropriateness, and risks of proposed care, surgery, or procedure, as well as discussions of treatment alternatives and advanced directives, if applicable. The medical record will contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the enrollee has executed an advance directive.	As described.
Documentation supporting that health and wellness promotion services have occurred within the context of a clinical visit or not.	All discussions regarding health education and wellness, whether they occurred within the context of a visit or a discussion with office staff.
Evidence of chronic illness management or acute care documentation	All Progress Notes regarding chronic illness treatment

General Medical Component (D)	
Element	**Standard**
COORDINATION OF CARE/FOLLOW UP AND OUTREACH:	
Are consultants used appropriately?	Document in the Medical Record Referrals to Consultants the MR reflects an appropriate utilization of Consultants.
Consultations promptly reviewed and followed.	All consultations reports, labs, imaging reports must be filed, reviewed, dated, and signed by a PCP.
Obtained Medical Records and Office Visits from PCP/specialties, if applicable.	Evidence of documentation from other providers present on the medical record, if applicable.
Provided MR to healthcare professionals, if applicable.	Provider met record requests, as required.
Follow-up after an ER visit or hospitalization.	If a member was seen in ER or was in Inpatient Status, a f/u must be done in the PCP's office, and also a copy of the Hospital and D/C Summaries must be placed in the Medical Record and dated.
Evidence of appropriate and timely referrals	Referrals made within a reasonable time frame depending on condition.
For records with multiple visits/admissions or complex and lengthy history diagnostic summaries are used in accordance with P&P.	All Medical Records with the annexed description must contain diagnostic summaries, updated as needed.
Documentation of referral	Documentation of referral services in the enrollee Record, including reports resulting from the referral

General Medical Component (D)	
Element	**Standard**
COORDINATION OF CARE/FOLLOW UP AND OUTREACH:	
All clinical information is available to authorized personnel any time the provider is open to patients.	Evidence that all clinical information is available to authorized personnel any time the office is open to patients.
Community resources are used, if applicable.	Any documentation of referrals to social services agencies, support groups.
Provider has read/consulted last office encounters or visits to other providers	Evidence that last office visit or visits to other providers have been read and reviewed.
Incorporation of records from previous transitions of care and summaries when a member is being transferred to a new provider or consultant. Evidence of attempts to collect records from previous providers or consultants.	Evidence of copies of previous records or attempts to providers, obtain them.

General Medical Component (D)	
Element	**Standard**
SUPPORTING DOCUMENTATION:	
Problem List maintained	An **Active** problem list is included and updated as needed
Record contains Immunization History.	An immunization record for children is up to date, or an appropriate history has been made in the record for adults. For children, there is a completed immunization history in the chart. **See schedule for vaccinations.**
Reports, histories, and physicals/progress notes reviewed	Lab reports, x-ray readings, op reports, and consultations) were reviewed, followed up significant problems, and incorporated in the record in a timely manner.
Documentation of Emergency care	Documentation of emergency care encounters in the Enrollee record with appropriate medically indicated Follow-up.
Significant patient advice given by telephone, online, provided after-hours is entered in the clinical records and appropriately signed or initialed	Progress note with this information included, if applicable.
Release of information contained in MR	If applicable
Treatment records from another current or transferring provider is present.	If applicable
Evaluation or member participation with Provider recommendations.	Progress note indicating members participation with providers' recommendation.
Evidence of preventive care ID documented in the record.	

General Medical Component (D)	
Element	**Standard**
SUPPORTING DOCUMENTATION:	
Evidence of End-of-Life care if applicable.	Progress Notes indication that end-of life care has been addressed, if applicable.

Maternity Medical Component (E)	
Element	**Standard**
Initial Prenatal care Visit	• Document when the first PN visit was rendered; 1st trim. • 42 days of Plan enrollment/3 wks. after dx/ 1 wk. of a pregnancy Dx. Referrals for comprehensive evaluation and Florida's Healthy Start prenatal risk screening. • 1st trimester visit within 3 wks. of a pregnancy diagnosis via + Human Chorionic G Gonadotropin (HCG) • 2nd trimester visit within 2 wks. of a pregnancy diagnosis via+ HCG • 3rd trimester visit within 1 wk. of a pregnancy diagnosis via + HCG • Evidence of contact if the enrollee fails to keep appointment and arrange for continued prenatal care as soon as possible. • Evidence of care coordination/case management depending on the needs of the enrollee
Pregnancy Hx and risks.	Pregnancy history and/or risks must include: G/P/Rh status/ Type of delivery/ Gestational age at delivery/ Anesthesia/ Length of labor/Birth outcome/risks/ Maternal complications/Sex/weight of child.
Medical-Surgical and Psychosocial Hx.	These must include: Serious accidents/Operations/ Infections/ Illness/Substance use/Mental health/Screening for depression/Gyn. Conditions/ Infertility/Stress/Living situation/ Socioeconomic evaluation.
Prenatal Care	A review of familial history of birth defect, deformities mental retardation, or inherited disease (for example, muscular dystrophy, hemophilia, cystic fibrosis). Maternal >35 years/paternal >50 years at time of delivery. Ethnicity.

Maternity Medical Component (E)	
Initial Prenatal care Visit	• Document when the first PN visit was rendered; 1st trim. • 42 days of Plan enrollment/3 wks. after dx/ 1 wk. of a pregnancy Dx. Referrals for comprehensive evaluation and Florida's Healthy Start prenatal risk screening. • 1st trimester visit within 3 wks. of a pregnancy diagnosis via + Human Chorionic G Gonadotropin (HCG) • 2nd trimester visit within 2 wks. of a pregnancy diagnosis via+ HCG • 3rd trimester visit within 1 wk. of a pregnancy diagnosis via + HCG • Evidence of contact if the enrollee fails to keep appointment and arrange for continued prenatal care as soon as possible. Evidence of care coordination/case management depending on the needs of the enrollee
Pregnancy Hx and risks.	Pregnancy history and/or risks must include: G/P/Rh status/ Type of delivery/ Gestational age at delivery/ Anesthesia/ Length of labor/Birth outcome/risks/ Maternal complications/Sex/weight of child.
Medical-Surgical and Psychosocial Hx.	These must include: Serious accidents/Operations/ Infections/ Illness/Substance use/Mental health/Screening for depression/Gyn. Conditions/ Infertility/Stress/Living situation/ Socioeconomic evaluation.
Prenatal Care	A review of familial history of birth defect, deformities mental retardation, or inherited disease (for example, muscular dystrophy, hemophilia, cystic fibrosis). Maternal >35 years/paternal >50 years at time of delivery. Ethnicity.
Preterm Delivery Risk Assessment	Documentation of preterm delivery risk assessment in the enrollee record by week twenty-eight (28)
Evidence of any necessary referrals	Referrals and follow-up, if applicable
Evidence of delivery arrangements	Assistance to enrollee in making delivery arrangements

Maternity Medical Component (E)	
Nutritional screening and counseling.	The Nutritional screening and counseling must include • Dietary intake/Hydration/Prenatal vitamins/Wt. loss/Wt. gain/ Elimination/Food/Shelter resources. • Evidence of provider promoted safe/adequate infant nutrition by promoting breast-feeding and use of breast milk substitutes. • Provider offered midlevel assessment. • Member provided individualized diet counseling and care plan by a public health nutritionist, a nurse, or a physician following the nutrition assessment. • Documentation of nutrition care plan by the person providing the counseling. • WIC referral for Nutritional counseling and enrollment in the Food and Nutrition Program for Women, Infants, and Children (WIC attached Referral Form) • WIC Referral (Children up to 5 y/o, Preg BF, Postop) with the current height and weight taken within 60 days of the WIC appointment and including Hb and Hct and nutritional problems. • Copy to the enrollee. Evidence for subsequent WIC certifications the Managed Care Plan shall ensure that provider coordinated with the local WIC office to provide the above referral data from the most recent well child visit and copy to the enrollee. • A copy of completed screening instrument is in the enrollee record, and proof that a copy has been provided to the enrollee.

Maternity Medical Component (E)	
Risk Behaviors/exposures	These must include an appropriate notation concerning: Tobacco/ETOH/Chemical Dependency/HIV/STD/Congenital Syphilis/Hepatitis HPV risks/Domestic violence/Safe sex practices/Sexual abuse/Safety risks, environmental/occupational/HIV Test recommendation & counseling 28 wks./32 wks. Signed objection if member declined HIV test. Infected member counseled and offered latest recommended ART regime, appropriate education and treatment referral/ If member HBsAg-positive report to the local CDC, regardless of HS score/Evidence that the provider performed a second HBsAg test between 28 and 32 weeks of pregnancy for enrollees who tested negative eat the first pre-natal visit but who are considered to be high-risk for Hepatitis B infection. Domestic Violence/Sexual abuse. Safe Sex Safety risks/environmental/occupational. HIV Test (initial visit/28 and 32 weeks. Signed objection if HIV test declined. If member infected she was counseled and offered latest recommended ART regimen. Offered appropriate education and referrals, including smoking cessation. Evidence of documentation of emergency care encounters with appropriate medically indicated follow-up.
Physical Exam	A Physical Exam must include: a comprehensive review of systems/a focused Gyn. Safe sex practices. And OB examination/ presenting complaints, if any/EDD confirmation/18-20 week EDD update.
Ongoing Prenatal Care Visits	General Visit Frequency: Every 4 weeks until 28/32 weeks* gestation/every 2 weeks until 36 weeks gestation/every week thereafter until delivery. Evidence of preterm risk assessment by week 28/evidence to f/u to members who fail appointment. Evidence of offering assistance in making delivery arrangements.
OB screening/each Prenatal visit	Each ongoing prenatal visit must include weeks' gestation Fundal height/Presentation/Fetal Heart Rate/Fetal movement. Preterm labor signs and symptoms/Cervical exam/Weight/BP/Urine albumin, glucose/Problems/comments.
Immunization	An appropriate immunization history has been made with notation that immunizations are up-to-date/scheduled for catch up. Documentation of communicable diseases.

Maternity Medical Component (E)	
Treatment plans	Treatment plans are clearly documented in the record and reflect: High risk patient/Specialty physician care/Dental care/Diagnostic Testing and counseling/Pregnancy Education and counseling.
Healthy Start Prenatal risk screen Form.	Evidence of a DH Form 3134 completed, and a copy given to the patient with referral services offered. Evidence that the provider submitted the prenatal risk assessment to the CHD in the county where the prenatal screen was completed within 10 business days of completion. Referral for services regardless of score.
Prenatal Zika Virus Screen	All pregnant women with a history of travel to an area with ongoing Zika virus transmission should be tested for infection. • If positive or inconclusive then consider serial fetal ultrasounds and consider amniocentesis. • If negative, one fetal ultrasound should be performed to detect microcephaly of intracranial calcifications. • If microcephaly or intracranial calcifications are present, then retest pregnant women and consider amniocentesis. • If negative for microcephaly or intracranial calcifications, then continue with routine prenatal care.
Delivery care	If the provider determines that the enrollee's pregnancy is high risk, documentation will evidence that the provider's obstetrical care during labor and delivery included preparation by all attendants for symptomatic evaluation and that the enrollee progress through the final stages of labor and immediate postpartum care.
Postnatal Screening Form	Evidence of transmission Healthy Start (Postnatal) Risk Screening Instrument Certificate of Live Birth to the County CHD within 5 business days of the birth. If the referral is made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the enrollee or infant is invited to participate based on factors other than score. If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, Hepatitis B, substance use or domestic violence.

Maternity Medical Component (E)	
Postpartum	The postpartum visit must include Date of delivery/Infant's birth weight Gestational age at birth, evidence of inspecting the newborn for abnormalities and/or complication. Type of birth: vaginal, C/S/Postpartum 7-84 days after delivery date, PE: BP, weight, pelvic exam, Abdomen, Breast exam, Education on postpartum changes/Personal health habits/Family planning to all women and their partners/Newborn care (eye medication, APGAR, admin 5 mg of vitamin K), Weight and measuring, inspection for abnormalities or complications/Evidence of continuing care of the newborn is provided through the CHCUP program component and documented in the child's medical records./ if the mother is RH negative there is evidence of securing a cord blood sample for type Rh determination and direct Coomb test, /Sexual activity/Nutrition/Signs of Depression Referral for community resources for mother and child made as appropriate. If member tested + for HBsAG, evidence of referral to the Perinatal Hepatitis B Prevention Coordinator at the local CHD. Evidence the infants born to HBsAg-positive enrollees receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable, preferably within twelve (12) hours of birth, and shall complete the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States. Evidence that infants born to HBsAg-positive enrollees for HBsAg and Hepatitis B surface antibodies (anti-HBs) are tested six (6) months after the completion of the vaccine series to monitor the success or failure of the therapy. Evidence that the informant born to the enrollee who tested positive for HBsAG was referred to the Healthy Start regardless of screening score. Evidence of provider report to the local CHD of any positive HBsAg result in any child age 24 months or less within 24 hours of receipt of the positive test result.

AIDS/HIV Preventive Component (F)	
Element	**Standard**
Initial History (HPI)	MR with date of first positive HIV test, last negative HIV test documented, care received, current CD4 count, and chart with lowest/highest CD4 count, chart with first and current viral load count, documentation if patient is participating in research studies.
HIV - Related Illnesses	Documentation of any opportunistic infections/cancer, documentation of TB test with results or IGRA, medications taken for anti-TB and HIV, documentation of missed doses and any side effects of medication, viral load, or CD4 count while taking medications.
Past Medical History	Documentation of past medical history
Past Surgical History	Documentation of past surgical history
GYN and Women's Health	Last pap smear test and result, LMP, breast examination/ mammograms, UTI or yeast infection documented
Obstetric	History of G/P/A/LB, HIV test done during pregnancy, children with positive HIV
Anorectal History	Anal Pap test and results, history of anal warts
Urologic History	UTI, prostate enlargement or infection, PSA test, and results
STD History	Documented history of STDs
Dental Oral Care	Oral health examination, dentures
Eye Care	Vision examination, dilated retinal examination
Medication List Maintained	List of current medications and side effects reviewed
Allergies Documented	Documentation of all allergies
Immunizations	Pneumovax, Tdap, Flu, H1N1, Hepatitis A, Hepatitis B, Chicken Pox, MMR.
Health-Related Behaviors	Tobacco use, ETOH use, Drug or Substance Use, exercise, Diet (raw milk, raw eggs, raw meat, raw fish, caffeine).
Gender Identity	Male/Female/Sex change
General Sexual Practices	Protection used during intercourse, sex with men/women/both, type of sex used, such as anal/vaginal/oral sex
HIV Prevention	Protection used to prevent transmission, whether partner also has HIV
Family History	Family history documented

AIDS/HIV Preventive Component (F)	
Social History	Social History documented
Mental Health History	History of mental health documented
ROS	Presence of s/s: tired, fever, night sweats, anorexia. Evidence of PE done: VS/BMI/nourishment/well or ill.
Assessment	Evidence of a complete assessment done
Plan	Care plan completed and revised frequently according to condition changes
HIV Education	Information on testing, Rx., treatment adherence and prevention of HIV transmission to fetus or sexual partners
Pediatric and Adolescent Preventive Component (G)	
Element	**Standard**
A Complete History & Physical Examination	A complete Medical History and Physical Exam must be done to all new patient (CC/HPI/All/PMH/PSHX/PSURGICAL HXFAMILY HX/ROS/VITAL SIGNS/PE: General/HEENT/Neck/Chest/Lungs/ Heart/Abdomen/Extremities/Nodes/Skin/Neurological evaluation/Gait/Hip abduction/Genitalia/Psychosocial Hx/Prenatal care/delivery/birth Hx. The CHCUP schedule is: Birth or neonatal examination. Within 3-5 days of birth and within 48-72 hours after discharge from a hospital, to include evaluation for feeding and jaundice. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge. By 1 m/2m/4m/6m/9m/12m/15m/18m/24m/30m/Once per year for 3 through 20 years old.
High Risk Behaviors and Anticipatory Guidance	Encourage patient on Nutritional status/Dental care-3 yrs. old and or referral/Injury prevention/safety/Report any violence or abuse. Social/Emotional Health/Depression/Advise on ETOH, cigarette, E-cigarettes, drug abuse beginning at age 11/encourage exercise/Illness Prevention/Sleep Positioning/HIV/STD/ Hepatitis Risk query teaching instructions with the parent or guardian/18 months and 24 months Screening for developmental delay.
Immunizations	An appropriate immunization history has been made with notation that immunizations are up to date/scheduled for catch up. Evidence of provider participation in FL SHOTS.

Pediatric and Adolescent Preventive Component (G)	
Measurements	Document Height/Wt./BMI /HC for each routine visits. BMI annually starting at age 2 yrs.
Sensory Screening	Vision Screening starting at age 3 years then at 4, 5, 6, 8, 10, 12, and 15 years of age. Hearing screening starting at age 4 years then at 5, 6, 8, 10 years of age, once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years.
General Screening	**Lead Testing** at 12 months and 24 months of age. Children between the ages of 36 and 72 mo. who have not been previously screened for lead poisoning. **H&H** at 12 mo. of age. **Urinalysis:** starting at 9 months of age, and patients at high risk. **Hereditary and Metabolic Screening processed through the State Public Health Laboratory:** Screening for PKU, Thyroid, Hemoglobinopathies, Galactosemia. If a child is found to have lead blood levels equal to or greater than 10 micrograms per deciliter, providers should use their medical discretion, with reference to the current Center for Disease Control and Prevention (CDC) guidelines covering patient management and treatment, including follow-up tests and initiating investigations as to the source of lead where indicated.
Procedures: At Risk	**TB Testing** for all pediatric patients and at risk. **Dyslipidemia screening:** To be done at ages 2-4-6-8 and once from 9-11 and each year from 12-16 and once between 17-21 or patients at risk. **HIV/STD/Hepatitis/Pelvic Exam/PAP Smear/Sickle Cell Test**: For all patients at risk/Family History.
Child Abuse	Screening for child abuse is conducted/suspected, and reported to appropriate regulatory agencies and documented.

Pediatric and Adolescent Preventive Component (G)	
Treatment Plan for Opioid Medications	Documentation of the express written and informed consent of the enrollee's authorized representative prescriptions for psychotropic medication (such as, antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years. (1) The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription. (2) The prescriber must ensure completion of an appropriate attestation form. (3) Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form. (4) Every new prescription will require a new informed consent form. **Opioid Medication** prescribed for the treatment of Acute Pain listed in Schedule II-limited to 3 day supply (pain related to cancer, terminal illness, palliative care, and serious traumatic injury are excluded from theses prescribing limits) **Acute Pain Exemption:** Pain listed in Schedule II – limited to 7 day supply.(pain related to cancer, terminal illness, palliative care and serious traumatic injury are excluded from these prescribing limits). **Prescription for Controlled Substance:** Controlled substances in Schedule III, IV, V for treatment of acute pain is limited to 14 day supply. (pain related to cancer, terminal illness, palliative care and serious traumatic injury are excluded from theses prescribing limits) Opioid Medication prescribed for the treatment of Acute Pain listed in Schedule II-limited to 3 day supply (pain related to cancer, terminal illness, palliative care, and serious traumatic injury are excluded from theses prescribing limits) **Acute Pain Exemption:** Pain listed in Schedule II – limited to 7 day supply.(pain related to cancer, terminal illness, palliative care, and serious traumatic injury are excluded from these prescribing limits). **Prescription for Controlled Substance:** Controlled substances in Schedule III, IV, V for treatment of acute pain is limited to 14 day supply. (pain related to cancer, terminal illness, palliative care and serious traumatic injury are excluded from these prescribing limits)

Safety Preventive Component (H)	
Element	**Standard**
Evidence of Staff training	Staff training on infection control and universal precautions. Evidence of boxes to dispose of hazardous materials and contaminated materials, and waste.
There are no potential hazards such as slippery floors, unsecured items or inaccessible emergency exits.	As described.
Emergency disaster plan	Evidence of Emergency/Disaster Preparedness Plan addressing internal/external emergencies for administrative offices and ensures member safety and evacuation plan.
After-hours access	Evidence of accessibility to after-hours services by asking the appropriate office staff to show next available appointment.
Safety Program	Management of identified hazards, potential threats, near misses, violence in the workplace, extreme threats like bomb threats, firearms, terrorism, and other safety concerns. Awareness of, and a process for, the reporting of known adverse incidents to appropriate state and federal agencies when required by law to do so. Processes to reduce and avoid medication errors, including expiration date monitoring on medications, reagents, and solutions. Evidence that the Thermometer log in the refrigerator is being read. Evidence that opened medication in the refrigerator is not over 28 days. Prevention of falls or physical injuries involving patients, staff, and all others.
Fire prevention	Evidence of staff education and fire drills (fire drills once a year). Local/Federal fire prevention regulations for all sites, if applicable. Compliance with applicable State/Local Building codes and regulations. Contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type. Have prominently displayed illuminated signs with emergency power capability at all exits from each floor or hall. Have emergency lighting, as appropriate to the facility, to provide adequate evacuation of members and staff in case of an emergency. Have stairwells protected by fire doors, if applicable.
Member Privacy/Accessibility	Provide examination rooms, dressing rooms, and reception areas that are constructed and maintained in a manner that ensures member privacy during interviews, examinations, treatment, and consultation.

Safety Preventive Component (H)	
Appropriate size and seating for waiting room	The organization has standards for the appropriate size and seating for waiting rooms, and there is no apparent overcrowding.
Have provisions to reasonably accommodate disabled individuals.	Self-Explanatory
Evidence that Members' Rights poster is prominently displayed.	Self-Explanatory
Posted information regarding lack of malpractice insurance coverage, if applicable. Information is ported in a prominent location.	Self-Explanatory
Other Related Items:	Verify that there is a documented policy defining the complaint threshold./ Ensure there is a system for capturing of complaints and all necessary details. Ensure are investigated and responded in a timely manner and resolutions and documented findings are provided.

Adult Family Care Home (AFCH)	
Element	**Standard**
RESIDENT RECORDS:	
Bill of Rights/Proc. Lodging complaints with Complaints with Residents	Documented Bill of Rights /List Lodging Residents
Discussion of House Rules	Documentation that show that House Rules were discussed
Resident record on the premises by provider	Documentation of the resident record on the premises kept by the provider
Resident Health Assessment (Form 1110)	Documented proof of a completed Resident Health Assessment (Form 1110) on file.
Residency Agreement	Residency agreement on file completed before or at admission
Residency Agreement	Residency agreement must have all required information filled out
Resident Advised Grievance and fair hearing process	Documentation of a Resident Advised Grievance and hearing process, if applicable.
Demographic information in each resident	Documentation of Demographic info on each resident on file
Complete accounting of resident funds for safekeeping	File indicating that a complete account of resident funds is being kept
Resident's medication	Documented record of each resident's Medication

Adult Family Care Home (AFCH)	
Annual Health Risk Assessment, or when significant changes occur	Documented Annual Health Assessment on file or when significant changes happen
Health Risk Assessment (HRA) conducted and signed by an authorized individual	HRA must be conducted and signed by a physician or other licensed practitioner of the healing arts defined as a Physician Assistant, Advanced Registered Nurse Practitioner, or Registered Nurse acting within the scope of their practice under state law; documented and signed
Service plan developed after the initial HRA	Documentation of a Service Plan developed within 15 days after the initial HRA, based on HRA information and containing all required information; signatures of a resident/legal guardian/ designated administrator must be present.
Medication orders	Documentation that medication orders are reviewed and current
Nursing Progress Notes	Documentation provided where it shows nursing progress notes are being kept when nursing services are provided
Special Diet for the member	Copy in the member's file of any special diet order prescribed by resident's healthcare provider.
Coordination of care	Documentation of the coordination of care by providers/licensed practitioner/nurse for the member
Any major incidents or significant health changes	Documentation of any major incidents or significant health changes and action taken in response to such incidents or changes
Monthly weight record	Documentation that monthly weights are being done for the member and in file; includes resident's name, admission weight, weighing, and recording of each resident on a monthly basis
Resident discharge notices sent by provider	Resident records shall contain a copy of any notice of discharge sent to the resident or the resident's representative
Closed resident records kept 5 yrs.	Closed resident records shall be kept for a period of five years after the resident leaves the AFCH. Ask the AFCH provider whether or not resident records are being retained by the home after a resident is discharged
Personal Needs Allowance (PNA) for the resident	Evidence, if applicable, that the resident has been provided with a PNA in an amount equal to that set by rule 65A-2.036, F.A.C.

Adult Family Care Home (AFCH)	
Element	**Standard**
FACILITY RECORDS/SAFETY:	
Facility Records	Documentation of facility records shall be on file on the premises and up-to-date
Resident Service Log (AHCA-Med Serv. Form 037-Appendix D, July 2009)	Evidence of a complete Resident Service Log (AHCA-Med Serv. Form 037-Appendix D, July 2009) on file; make sure log is filled out properly (Resident name, Medicaid #, facility name, month/year)
Certification of Medical Necessity for Evidence of a Certification of Medical necessity for Medical Medicaid ACS-AHCA-Med Ser., Form 035	ACS-AHCA-Med Ser., Form 035; this form needs to certify that the recipient is in need of an integrated set of assistive care services on a 24-hour basis, which includes at least two of four service components on a daily basis; make sure that it is filled out completely.
Admission/Discharge log	Evidence of an admission/discharge log on file for residents on the premises.
AFCH License	Evidence of an AFCH license available upon request to public.
Current county health department inspection.	Evidence of a current county health department inspection on file.
Current fire safety inspection	Evidence of a current fire safety inspection for the AFCH must be kept on file and ready for agency inspection.
Radon Testing (If applicable)	Documentation of radon testing shall be kept on the premises by the provider and ready for agency inspection for AFCHs located in counties requiring radon testing.
Emergency Plan	Evidence of an emergency plan kept by provider on the premises and in file; the AFCH shall have a written plan which specifies emergency and evacuation procedures for fires and such natural disasters as hurricanes, floods, and tornadoes. There should also be an indication that the plan's emergency and evacuation procedures have been reviewed with the residents, the relief person, all staff, and all household members.
Survey, complaint investigation reports, and notices of sanctions and moratoriums issued to the AFCH	Evidence that the AFCH providers are keeping on the premises all completed survey and complaint investigation reports, and notices of sanctions and moratoriums issued to the AFCH by the agency within the last 3 years.

Adult Family Care Home (AFCH)	
Emergency telephone numbers Emergency telephone numbers	Verify that the emergency telephone numbers are located by a designated telephone and includes emergency # 911, police #, fire dept. #, ambulance #, Florida Poison Info Ctr. #, Abuse Hotline#, AHCA's Field Office.
Information regarding a resident's location to essential medical services providers in disaster/emergency situations	Evidence that in the event of a disaster/ emergency, the AFCH provider can make available all necessary information regarding a resident's location to essential medical service providers, both during and after the disaster/emergency.
Proof of fire safety inspection every 365 days	See Element and Standard #29
Written emergency evacuation procedures/rev	See Element and Standard #31
Emergency and first aid supplies	Check to see that the provider at all times maintains first aid and emergency supplies including a 3-day supply of non-perishable food based on the number of residents and household members currently residing in the home, and 2 gallons of drinking water per current resident and household member.
Telephone available/accessible for residents' use	Evidence that the ACFH, at a minimum, maintains a telephone in the home which is available and accessible for the resident's use at all times and placed in an area that allows facilitated private communication.
Non-ambulatory/impaired residents on ground floor	Verify that residents who are non- ambulatory or who require assistance with, or supervision of, ambulation are housed on the ground floor.
Grab bars for physically handicapped; hot water supervision	Verify that the bathrooms used by physically handicapped residents have grab bars for toilets, bathtubs, and showers; verify that hot water temperature is supervised for persons unable to self-regulate water temperature.
Safety cover on hot tub/spa	Evidence that if the home has a hot tub or spa that it has a safety cover when not in use.
Supervision/aware resident whereabouts/ ensures safe/reminding of appointments and unattended no more than 2 hours	Evidence that the AFCH provider is providing general supervision 24 hours per day, where the provider is aware of the resident's whereabouts and well-being while the resident is in care of the AFCH. The resident may be with no supervision in an AFCH for up to 2 hours in a 24 hour period, as long as approved by the provider**.**

Adult Family Care Home (AFCH)	
Report significant physical/mental changes, weight loss	Evidence that the AFCH provider is being responsible in observing, recording, and reporting any significant changes in the resident's normal appearance, behavior or state of health; significant changes include a sudden or major shift in behavior or mood; a deterioration in health status, such as unplanned weight change, stroke, heart condition, or stage 2 pressure sore. Evidence of timeliness of LTC CM communication of all admissions, discharges, and ER visits within 48-hours.
Medication Standards	Determine that correct assistance/supervision is being made when meds are given; that self-administration of meds is being encouraged verbally by trained staff; trained staff may also make available such items as water, juice, cups and spoons; trained staff must observe the resident take the medication; proof that for the facilities that provide medication administration that there is a staff member that has a license to administer meds in accordance with a health provider's order or prescription label to meet requirements; Documented proof that a list of all current prescribed meds is in file; Documented proof that a nurse is managing a pill organizer and/or list of centrally stored meds in container.

Adult Living Facility	
Element	**Standard**
RESIDENTS' RIGHTS:	
Residents' rights posted.	Residents' rights must be visibly posted.
Residents informed of their rights.	Resident must be informed about their rights, documented in MR.
Safe and Homelike environment.	Review if environment is homelike and safe for the resident.
Use of needed adaptive equipment.	If resident has and uses the adaptive equipment needed for their condition and safety.
Resident participating in activities.	Review if resident is participating in activities.
Resident participation in selecting activities.	If resident was given opportunity to select activities.
Member's opinion about their room & general Environment.	Self explanatory.
Transportation arranged for medical appointments	Review in Medical records notation about transportation for medical appointments.

Adult Living Facility	
Encourage resident to participate on their care.	Notes about staff encouraging residents to participate in their care.
Resident funds for safekeeping	Staff keeps money or possessions for residents and give it back when resident needs/wants them.
Resident having their medicines all the time	Resident never run out of medications.
Medication's assistance for residents	Resident is receiving assistance with medications; type of assistance must be noted at MR.
Resident receiving assistance with other services	Residents receiving assistance with other services as needed, must be documented at MR.
Quality of food service	Resident opinion about food service in the facility.
Staff attention to residents	How does staff communicate with residents and responds to their concerns. Are residents informed about their rights?

Adult Living Facility	
Element	**Standard**
RECORD REVIEW:	
Height and weight	Documented correct height and weight on MR.
Diagnosis	Documented correct diagnosis and is in member's chart.
Allergies	Documented all of the member's allergies.
ADLs assessment and score	Documented full ADL (Activities of Daily Living) assessments and scores.
Evidence of special precautions taken	Documented all special precautions taken at this facility. (in other words, fall precautions, skin breakdown precautions, universal precautions, UTI precautions, precautions for PU).
Evidence of cognitive and behavioral assessment	Documented proof of assessment(s) done on member to determine their cognitive and behavioral levels.
If evidence of Pressure Ulcer stage II present in Member	Documented notes where it shows proof of wound care, any observations made by the RN and any notations if the wound is improving within 30 days.
Any significant changes in member's health	Documented any significant changes in member's health on MR.
Evidence of appropriate people notified of member's changes in their condition	Documented evidence that indicates that if there are any changes in the member's condition the significant people are notified (Family, guardian, CM, PCP, Psych/SW.

Adult Living Facility	
Medications	Indication that the medications ordered for the member are documented in the member's file
Annual MD evaluation of medical restraints	Documentation of annual MD evaluation for restraints.
Renewal of Restraints' Orders	Documented proof that Orders for Restraints have been renewed (if applicable).
Form 1823 completion	Demonstrate that Form 1823 (Resident Health Assessment for Assisted Living facilities) is Filled out completely.
Photo ID of resident at elopement risk (if applicable)	Proof of a photo ID for resident if they are at risk of elopement.
Hospice services care plan on file (if applicable)	Proof of care plan for hospice services on file (if applicable).
ALF House Rules and Bill of Rights	Proof of copy of ALF House Rules and Bill of Rights.
Contract signed by the guardian/surrogate (if applicable)	Proof of a contract signed by a guardian/ surrogate for the member. Evidence of timeliness of LTC CM communication of all admissions, discharges, and ER visits within 48-hours.
LTC CM communication	Evidence of timeliness of LTC CM communication of all admissions, discharges, and ER visits within 48 hours.
Safety Component	Determine if the environment for the ALF is clean and comfortable, home-like; are there NO safety hazards observed; look at adaptive equipment to make sure that it is clean and well maintained; look at the resident's appearance to make sure that it is well overall. Documentation or observation of restraints use. Make sure all medications are stored and secured properly; analyze if the staff is able to perform their duties; no evidence of allegations or suspect of abuse/neglect or exploitation.
Medication Standards	Determine that correct assistance/supervision is being made when medications are given; that self-administration of meds is being encouraged verbally by trained staff; trained staff may also make available such items as water, juice, cups and spoons; trained staff must observe the resident take the medication; proof that for facilities that provide medication administration that there is a staff member that has a license to administer meds in accordance with a healthcare provider's order or prescription label to meet requirements; Documented proof that a list of all current prescribed meds is in file; Documented proof that a nurse is managing a pill organizer and/or list of centrally stored meds in original container.

Skilled Nursing Facility	
Element	**Standard**
RECORD REVIEW:	
Member Name	Each page in the record contains member name of member ID number.
Each page in the record contains member name of member ID number.	Each page in the record contains member name of member ID number. Personal data includes address, employer, telephone numbers, Emergency contact, marital status.
All entries signed/dated	Including dictation are signed or initiated by the licensed professional. NA notes are to be cosigned by the supervising professional. All verbal orders are cosigned by the physician. All entries are dated.
The record is legible	All parts of the enrollee record are legible.
Advanced directives	There is documentation of Advanced Directives being discussed and copy of the document if executed. DNR documentation if applicable.
Medication list	Medication list is up-to-date. There is a medication list with dosage and frequency of medication. Effectiveness of PRN medications is documented.
Administered medications	Evidence that all administered medications are recorded when Given. Entries have complete signatures.
Medication Review	Evidence of medication review as required by member condition. At a minimum medications are reviewed annually.
Allergies	Allergies and adverse reactions are prominently displayed on the member's chart.
Past nursing history	Past nursing history, including serious injuries, operations, and illnesses, and secondary conditions, and any other disorders that impact the member's care.
Past medical history	Past medical history, including the physician's history, member's physical exam, and the current need for care.
Tobacco use	Tobacco use/non-use, including tobacco, chew, and pipe.
Alcohol/drugs use	Alcohol/ Illicit drugs/Legally prescribed drugs assessment
Diagnosis	Diagnosis is clearly related to services being rendered and the symptoms described.

Skilled Nursing Facility	
Nutritional assessment	Documentation of a nutritional assessment. Documentation of nutritional needs and responses at least quarterly.
Functional assessment	Documentation of functional assessment. Documentation includes skilled observations/assessment.
Pain assessment	Documentation on pain assessment.
Interdisciplinary team	There is documentation of an interdisciplinary team approach to care.
Physician's orders	Physician orders must be in writing and present in the record.
Member seen by physician	Evidence that the member has been seen by a physician or another licensed professional acting within their scope of practice at least 1X/30 days for the first 90 days and at least 1X/60 days thereafter.
LTC CM Communication	Evidence of Timelines of LTC CM communication of all admissions, discharges, and ER visits within 48-hours
Plan of care	Plan of care completed 7 days after the assessment, within 14 days of admission, and every 12 months thereafter. Plan of Care reviewed every 3 months of promptly after a significant change. Plan of care must include functional limitations and be written collaboration with the member, family, or responsible party at the member's option.
Discharge planning	There is documentation of discharge planning and a discharge summary signed by physician within 30 days of discharge.
Social services	Evidence that social services are provided by a staff member with the appropriate training and experience, and who is responsible for making integration arrangements so the member can return back into the community, transfer to a home, or transfer to another facility where appropriate level of care is available.
Relevant information	There is documentation of relevant information to the PCP/ordering physician on a regular basis, and at discharge. There is evidence of continuity and coordination of care between all members of the treatment team.
Designated FT employee	There is designated FT employee responsible and accountable for the facility's medical records. If this employee is not a qualified Medical Record Practitioner, then the facility shall have the services of a qualified Medical Record Practitioner on a consultant basis.

Skilled Nursing Facility	
Element	**Standard**
MEMBERS' RIGHTS	
Statement posted	Statement of Member Rights posted
Resident bills of rights copy	Evidence that members have been given a copy of the resident's bill of rights and that these have been discussed with the member.
Right to private communication	Rights statement include the right to have private communication with any person of their choice.
Right to present grievances	The right to present grievances on behalf of himself, herself, or others to the facility's staff or administrator, to government officials, or to any person without fear of reprisal, and to join with other patients or individuals to work for improvements in patient care.
Right to be fully informed	The right to be fully informed in writing, prior to, at the time of admission, and during their attendance, of fees and services not covered.
Right to be adequately informed	The right to be adequately informed of their medical condition and proposed treatment unless otherwise indicated in the written medical plan of treatment by the physician, and to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated in the written medical plan of treatment by the physician, and to know the consequences of such actions.
Right of adequate care	The right to receive adequate and appropriate healthcare consistent with established and recognized practice standards within the community and with rules as promulgated by the AHCA.
Right to privacy	The right to have privacy in treatment and in caring for personal needs, and confidentiality in the treatment of personal and medical records.
Right to be treated courteously	The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement of the services provided by the facility.
Right to freedom of choice	The right to freedom of choice in selecting a nursing home.
Staff training	Evidence that staff has been trained regarding residents' rights.

Skilled Nursing Facility	
Element	**Standard**
SAFETY:	
Isolation	Members with communicable diseases are adequately and appropriately isolated.
Incidents report	Evidence of a system to report accidents, adverse, critical, or unusual incidents to the Plan and to AHCA.
Staff Education	Staff Education plan contains prevention and control of infection, fire prevention, life safety and disaster preparedness, accident prevention, and safety awareness program.
Environment	Environment is safe, clean, comfortable, and home-like, and it allows the member to sue personal belongings to the extent possible.
Disaster preparedness	Evidence of written Disaster Preparedness plan to be followed in the event of an internal or externally caused disaster.
Evidence of procedures	Evidence of procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of the members
Drugs and biologicals	Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, Chapter 499, F.S., and Chapter 64B16, F.A.C. Drugs and non-prescription medications requiring refrigeration shall be stored in a refrigerator. When stored in a general-use refrigerator, they shall be stored in a separate, covered, waterproof, and labeled receptacle.
Controlled substances	All controlled substances shall be disposed of in accordance with state and federal laws. All non-controlled substances may be destroyed in accordance with the facility's policies and procedures. Records of the disposition of all substances shall be maintained in sufficient detail to enable an accurate reconciliation.

Skilled Nursing Facility	
Element	**Standard**
ADDITIONAL STANDARDS FOR SNF THAT ADMIT CHILDREN 0-20:	
Evidence of assessment	Evidence of an assessment upon admission by licensed physical, occupational, and speech therapists who are experienced in working with children.
Determination of level of care	There is determination of LOC made a physician (intermediate/skilled/fragile nursing care).
Evidence of written order	Evidence of a written order by the child's attending physician in consolation with parents/legal guardians.
Medicaid certification	For Medicaid certified nursing facilities, the recommendations for placement of a Medicaid applicant or recipient in the nursing facility shall be made by the Multiple Handicap Assessment Team. Consideration must be given to relevant medical, emotional, psychosocial, and environmental factors.
Physician's orders	Documentation of Physician's orders, diagnosis, medical history, physical examination, and rehabilitative or restorative needs.
Preliminary evaluation	A preliminary nursing evaluation with physician orders for immediate care, completed on admission.
Standardized assessment	A comprehensive, accurate, reproducible, and standardized assessment of each child's functional capability, which is completed within 14 days of the child's admission to the facility and every twelve months thereafter. Assessment reviewed no less than once every 120 days or promptly after a significant change.
Plan of care	The plan of care should contain measurable objectives and timetables to meet the child's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. The Plan of care is completed within 7 days after the assessment and reviewed every 60 days.
Education	For children 3-15 there is evidence of home-bound education or attempts made by the facility to engage the County School Board. Children 16 - 20 years are enrolled in an education program according to their ability to participate.
Evaluation and documentation	Evidence that evaluation and documentation on the status of the child's condition is done at least monthly.
Verbal orders	Verbal orders are signed within 72 hours after the order was given.

Skilled Nursing Facility	
Activities	There are indoor and outdoor activities designed to encourage exploration and maximize the child's capabilities, and that accommodate mobile and non-mobile children. Outdoor activities are held in secure areas with areas of sun and shade, free of safety hazards, and equipped with age-appropriate recreational equipment for the developmental level of children and have storage space for the same.
Emergency Medication Kit	The facility shall maintain an Emergency Medication Kit of pediatric medications, as well as adult dosages for those children who require adult doses.
Transportation	The facility must provide access to emergency and other forms of transportation for children.
Life support certification	At least one licensed healthcare staff person with current Life Support certification for children shall be on the unit at all times where children are residing.
Pediatric equipment	Pediatric equipment and supplies shall be available as follows: Suction machines, oxygen, thermometers, sphygmomanometers, an apnea monitor, and a pulse oximeter.

Skilled Nursing Facility	
Element	**Standard**
ADDITIONAL STANDARDS GERIATRIC OUTPATIENT NURSE CLINIC:	
Maintain clinical record	The clinic shall maintain a clinical record for every patient receiving health services that contain the following: Identification data, including name, address, telephone number, date of birth, sex, social security number, clinic case number if used, next of kin or guardian and telephone number, name, and telephone number of patient's attending physician.
Healthcare plan	Healthcare plan including diagnosis, type, and frequency of services, and when receiving medications and medical treatments, the medical treatment plan and dated signature of the health professional licensed in this state to prescribe such medications and treatments.
Clinical notes	Clinical notes, signed and dated by staff providing service.
Progress notes	Progress notes with changes in the patient's condition.
Services rendered	Documentation of services rendered with progress reports/Observations.

Skilled Nursing Facility	
Instructions	Instructions provided to the patient and family.
Consultations	Evidence of consultation reports
Case conferences	Documentation of case discussion
Report to physicians	Documentation of reports provided
Termination summary	Termination summary including the reasons for the termination, dates of first and last visit, total number of visits by discipline, evaluation of achievements of previously established goals, and condition of the member at discharge.
Confidentiality	All clinical records shall be maintained confidentially according to the law.
Prescriptions	All prescriptions for medications shall be noted on the patient record, and include the date, drug, dosage, frequency, method or site of administration, and the authorized healthcare professional's signature.
Verbal orders	All verbal orders for medication or medication changes shall be taken by the clinic registered nurse or physician's assistant. Such must be in writing and signed by the authorized healthcare professional within eight (8) days and added to the member's records.
Administered medications	The clinic registered nurse or physician's assistant shall record and sign for each medication administrated, by drug, dosage, method, time, and site on patient's record.
Emergency plan/Kit	An emergency plan for reversal of drug reaction to include the facility's PRN standing orders for medications available in the emergency medication kit. If there is not a separate emergency medication kit in the clinic, the facility's emergency medication kit shall be immediately accessible for use in the outpatient clinic.
Prescribed medications	Prescribed medications for individual outpatients may be retained in clinic. These medications shall be stored separately from those of the nursing home in-patients for preventive measures and treatment of minor illnesses. Multi-dose containers shall be limited to medications or biologicals commonly prescribed for preventive measures and treatment of minor illnesses.

Long Term Care	
Element	**Standard**
Demographic Data	Complete Administrative Component.
Contact Information	Emergency Contact Information Legal data: guardianship papers, court orders, release forms.
Permission/Consent	All permission, consent forms, assessments, evaluations, medical, and medication information.
Eligibility	Copies of eligibility documents, including level of care determination by CARES and LOC determinations.
Healthcare Practitioner	Name and contact information of PCP.
Current Medical Condition	Enrollee's current medical/functional/behavioral health status, including strengths and needs.
Enrollee's support system	Identification of family/informal support system or community resources and their availability to assist the enrollee, including barriers to assistance; • Documentation of interaction and contacts (including telephone contacts) with enrollee, family of enrollees, service providers, or others related to services • Documentation of issues relevant to the enrollee remaining in the community with supports and services consistent with their capacities and abilities. This includes monitoring achievement of goals and objectives as set forth in the plan of care.
Enrollee's Participation	Enrollee's ability to participate in the review and/or who case manager discusses service needs and goals with if the enrollee was unable to participate. • Environmental and/or other special needs, if applicable.
Assessments	Needs assessments, including all physician referrals.
Plan of Care	Plan of care documented on medical record.
ALF residents	For enrollees residing in ALFs and AFCHs or receiving ADHC services, evidence of documentation of enrollee's response to HCB Settings Requirements queries and enrollee limitations.
Residential agreement	Agreement between facilities and the enrollee.
Authorizations	Record of Services authorization.
Assessments	CARES assessment documents.

Long Term Care	
Enrollee's Program information	Documentation that the enrollee has received and signed, if applicable, all required plan and program information (including copies of the enrollee handbook, provider directory) • Documentation of the discussion with the enrollee on the procedures for filing complaints and grievances; • Documentation of the choice of a participant-directed care option; • Documentation of the choice of PDO, initially, annually, and upon reassessment. • Documentation of the signed participant agreement.
Notices to Enrollee	Notices of Action sent to the enrollee regarding denial or changes to services (discontinuance, termination, reduction, or suspension) if applicable • Enrollee-Specific correspondence
Submission to DCF	Proof of submission to DCF of the completed CF-ES 2506A form.
Physicians' orders/evaluations	• Physicians' orders for LTC services and equipment. Provider evaluations, assessments, and/or Progress Notes (Home Health, Physical Therapy, Behavioral Health)

Long Term Care	
Case Management	Case Management Files - Case management enrollee file information is maintained by the Plan in compliance with state regulations for record retention. Per 42 CFR 441.303(c) (3), written and electronically retrievable documentation of all evaluations and re-evaluations shall be maintained as required in 45 CFR 92.42. The Plan specifies in policy where records of evaluation and re-evaluations of level of care are maintained and exchanged with the CARES unit. • Case notes including documentation of the type of contact made with the enrollee and/or all other persons who may be involved with the enrollee's care (for example, providers) • Copy of the contingency plan and other documentation that indicates the enrollee/authorized representative has been advised regarding how to report unplanned gaps in authorized service delivery; copy of the disaster/emergency plan for the enrollee's household that considers the special needs of the enrollee. • Documentation of choice between institutional, home, and community-based services (HCBS). • Evidence of Care for Older Adults (COA) documentation • Documentation of choice between institutional and home and community-based services. • Evidence of Timelines of LTC CM communication of all admissions, discharges, and ER visits within 48 hours. • Information from quarterly face-to-face visit that addresses at least the following: a. Enrollee's current medical/functional/behavioral health status, including strengths and needs. b. Identification of family/informal support system or community resources and their availability to assist the enrollee, including barriers to assistance. c. Enrollee's ability to participate in the review and/or who case manager discusses service needs and goals with if the enrollee was unable to participate, and d. An assessment of the enrollee's environment, including fall risk screening, and/or other special needs. e. Environmental and/or other (for example, safety risks, sanitation, need for physical adaptations, general condition of the home, amount of space, adequacy of sleeping area, access to the bathroom, temperature, availability of food).

Behavioral Health	
Element	**Standard**
Demographic Data	Complete Administrative Component.
Contact information	Emergency Contact Information; Guardian Contact, if applicable.
Consent	Consent for Behavioral Health treatment that is signed by the recipient or the recipient's legal guardian. An explanation must be provided for signatures omitted in situations of exception.
Evaluation/Assessment	Evidence of evaluation or assessment that is signed by the recipient or legal guardian, if applicable. Evaluation contains: Components of a brief behavioral health status exam. Evaluation is conducted by a physician, psychiatrist, a licensed practitioner of the healing arts (LPHA), or master's level certified addictions professional (CAP) for diagnostic and treatment planning purposes. • For new admissions, the evaluation or assessment by an LPHA for treatment planning purposes must have been completed within the past six months; • Copies of relevant assessments, reports, and tests; • Service notes (progress toward treatment plans and goals) • Documentation of service eligibility, if applicable. • Current treatment plans (within the last six months) • Current treatment Plan reviews and addenda. • Copies of all certification forms (for example, comprehensive behavioral health assessment). • The practitioner's orders and results of diagnostic and laboratory tests. • Documentation of medication assessment, prescriptions and medication management • Copy of the Preadmission Screening and Resident Review (PASRR) Level I and II present on the record, if applicable.

Behavioral Health	
Service Documentation	Recipient's Name; Date the service was rendered; Start and end times; Identification of the setting in which the service was rendered; Identification of the specific problem, behavior, or skill deficit for which the service is being provided; Identification of the service rendered. Updates regarding the recipient's progress toward meeting treatment related goals and objectives addressed during the provision of a service. • Dated signature of the individual who rendered the service • Printed or stamped name identifying the signature of the individual who rendered the service and the credentials (for example, licensed clinical social worker) or functional title (for example, treating practitioner)
Telemedicine	If telemedicine, services must be delivered from a facility enrolled in Medicaid as a community behavioral health services provider.
Presenting Problems	Presenting problems, along with relevant psychological and social conditions affecting the enrollee's medical and psychiatric status, are documented in the treatment record; relevant medical conditions are listed, prominently identified, and revised as appropriate in the treatment record. • Special status situation, such as suicidal ideation, or elopement potential, are prominently noted, documented, and revised in the treatment record in compliance with Simply Healthcare written protocols.
Allergies	Allergies, adverse reactions, or no known allergies are clearly documented in the treatment record.
Medical History	A medical and psychiatric history is documented in the treatment record, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports. This should include history of trauma, assessment of suicide risk and risk for aggressive behavior, and history of psychiatric hospitalization and ED visits for psychiatric issues.

Behavioral Health	
Enrollees 12 and older	Documentation in the treatment record includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs. N/A if the enrollee is under the age of twelve. • A mental status evaluation that includes the enrollee's affect, speech, mood, thought content, judgment, insight, attention, concentration, memory, and impulse control is documented in the treatment record. • A DSM-5-TR/ICD-10 diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data, is documented in the treatment record • Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated time frames for goal attainment or problem resolution. • The focus of treatment interventions is consistent with the treatment plan goals and objectives.
Records	Each treatment record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills. For non-prescribing practitioners, each treatment record indicates what medications have been prescribed and the name of the prescriber. N/A is scored if medications are not prescribed.
Informed Consent	Informed consent for medication and the enrollee's level of understanding is documented. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (for example, MSW, PhD)
Medications	When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A is scored if medication is not prescribed, or the practitioner being reviewed is not a prescriber (for example MSW, PhD)
Progress Notes	Progress notes describe enrollee strengths and limitations in achieving treatment plan goals and objectives.
Homicidal/Suicidal	Enrollees who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care. N/A is scored if the enrollee is not homicidal, suicidal, or unable to conduct activities of daily living.

Behavioral Health	
Treatments	The treatment record documents preventive services, as appropriate (for example, relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources). • The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan. • There is evidence that the clinical assessment is culturally relevant (for example, addresses issues relevant to the enrollee's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level) • The treatment record has evidence of continuity and coordination of care between behavioral health institutions, ancillary providers, and or consultants. There is evidence in the record of coordination of care with the PCP or declination of this coordination by the enrollee.; • The treatment record reflects evidence of coordination of care with other outpatient behavioral health practitioners • The record reflects evidence of coordination with the EAP/employer if a referral was made; The record reflects linking to community services or other support services.

Behavioral Health	
Element	**Standard**
ABUSE AND DOMESTIC VIOLENCE:	
Reports and Evidence	Evidence that suspected or reported vulnerable adult/child abuse is reported to the appropriate authorities.; Evidence that the Plan was notified within 24 hours of awareness of the incident; Evidence that the provider screened enrollees for signs of domestic violence and provided referral services to applicable domestic-violence prevention community agencies.

Behavioral Health	
Element	**Standard**
CHILDREN AND ADOLESCENTS:	
Records Only	For children and adolescents, prenatal and perinatal events, along with a complete developmental history including physical, psychological, social, intellectual, and academic, are documented in the treatment record. N/A if the enrollee is over the age of 18. • The record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the enrollee, unless contraindicated. • The record indicates the parent(s) or caretaker(s) have given signed consent for the various treatments provided. • The record shows evidence of an assessment of school functioning. • The record shows evidence of coordination with the youth's school to achieve school related treatment goals. • Documentation of the express written and informed consent of the enrollee's authorized representative for prescriptions for psychotropic medication (in other words, antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for an enrollee under the age of thirteen (13) years.
Coordination of Care	• Evidence of a signed release of information to the PCP • Evidence of a signed release of information to other practitioners • Evidence that treatment practitioner contacted, collaborated, and received clinical information from or communicated in any way with the other BH or medical providers and/or prescribers of medication • Evidence of collaboration, contact, and exchange of information with EAP, schools, and other agencies, if applicable • Information exchanged is accurate • Information exchanged is sufficient and complete providing adequate data for the provision of care • Exchange of information was timely and did not cause delay in care • Information exchanged is easy to understand.

Behavioral Health	
Major Depression – 296.2 or 296.3 Series (please see below for ICD-9 to ICD-10 conversion).* * Please add additional digits for specificity as needed: 296.2 > F32.x 296.3 > F33.x	• Evidence of a comprehensive assessment that takes into account both the degree of functional impairment and /or disability associated with the depression and the duration of episode, history of depression and comorbid mental health or physical disorders, any past history of mood elevation, any past experience of, and response to treatments, the quality of interpersonal relationships, living conditions and social isolation, culture, social determinants and support system. • OB/GYN and maternity history, if applicable. • Evidence of substance use/abuse screening. • Mood symptoms and suicidality are assessed at every visit; Co-morbid problems are assessed upon initial evaluation and at least annually. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. • N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (for example, MSW, PhD)
Schizophrenia – 295 Series (please see below for ICD-9 to ICD-10 conversion).* * Please add additional digits for specificity as needed: 295 > F20.x	There is evidence of an assessment of positive signs of psychosis (for example, delusions and/or hallucinations). • Co-morbid problems are assessed upon initial evaluation and at least annually • When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (for example, MSW, PhD) • When anti-psychotic medications are prescribed, there is evidence of observation for side effects, including EPS such as dystonic reactions, akathisia (“can’t sit still”), or akinesia. {Note: this applies to all discipline levels; N/A may not be checked)

Behavioral Health	
ADHD- 314.00; 314.01; 314.9 (please see below for ICD-9 to ICD-10 conversion).* * Please add additional digits for specificity as needed: 314.00 > F90.x 314.01 > F90.x 314.9 > F90.9	• The record reflects the active involvement of the family/primary caregivers in the assessment and treatment of the enrollee unless contraindicated. N/A is scored if contraindicated. • Co-morbid problems are assessed upon initial evaluation and at least semi-annually. • The record reflects education about ADHD and parent training in behavioral management. • When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A is scored if medication is not prescribed or the practitioner being reviewed is not a prescriber (for example, LCSW, PhD) • When medication is prescribed, there is evidence of an evaluation of the enrollee's response to medication and adjustments as needed.
Bipolar Disorder - 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89 Series (please see below for ICD-9 to ICD-10 conversion).* * Please add additional digits for specificity as needed: 296.0x >F31.x 296.40 > F31.x 296.4x > F31.x 296.5x > F31.3x 296.6x > F31.6x 296.89 > F31.8x	Mood symptoms and suicidality are assessed at every visit. • Co-morbid problems are assessed upon initial evaluation and at least annually. • When medications are prescribed that require serum level monitoring and/or laboratory tests to screen for medication side effects, those tests are conducted as recommended by the drug manufacturer. N/A is scored for non-prescribing practitioners (for example, MSW, PhD).
Diabetes Screening/Monitoring and Cardiovascular Disease for Patients with Schizophrenia or Bipolar Disorder	• There is evidence of diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications • There is evidence of care coordination with PCP/Specialist treating the diabetes to ascertain appropriate monitoring • There is evidence of care coordination with PCP/Specialist treating cardiovascular disease for patients with schizophrenia or bipolar disorder.

Behavioral Health	
Co-Occurring Psychiatric and Substance Related Disorders **List One** – Psych Diagnoses Major Depression – 296.XX Bipolar Disorder – 296.XX Schizophrenia – 295.XX Depressive Disorder NOZ – 311 (please see below for ICD-9 to ICD-10 conversion).* * Please add additional digits for specificity as needed: 296.xx > F31.x 311 > F32.A 292.xx > F19.x 304.xx > F19.2x 305.xx > F19.1x	**List Two** – SA Diagnoses Psychoactive Substance Intoxication and Withdrawal 292.XX Psychoactive SA Induced Disorders 292.XX Psychoactive Substance Dependence 304.XX Psychoactive Substance Abuse 305.XX - Follow-up after discharge from inpatient care within 7 days - Treatment plan includes identification of barriers to adherence and interventions that address these barriers. - Treatment plan includes relapse plan, including identification of relapse triggers, skills needed to deal with triggers, and contingency plan for difficult instances - Treatment plan includes both SA and psychiatric issues and interventions
Opioid-Related Disorders – 304.00, 305.50, 292.89x, 292.81x (please see below for ICD-9 to ICD-10 conversion).* * Please add additional digits for specificity as needed: 304.00 > F11.xx 305.50 > F11.xx 292.89x > F19.xx 292.81x > F19.xx	Withdrawal evaluation completed within 24 hours to determine the level of detoxification services needed (level I D through level IV D, refer to ASAM PPC-2 • The evaluation includes the documentation of consideration of appropriate pharmacotherapy for substance use disorder. Rationale is provided for each component of the treatment plan including additional medications • Co-occurring) disorders should be assessed to identify both medical and psychiatric symptoms, which may be masked by substance use. If a co-occurring disorder is present, there must be evidence of coordination of care with the medical provider. • Evaluation of behaviors correlated with continues use and abuse of illicit drugs • Family/support system involvement in treatment, when appropriate.

Social Determinants of Health	
Element	**Standard**
Economic stability	Evidence of screening for financial problems, housing, living situation, utility needs, and employment. Food insecurity/ Transportation Needs.
Education	Level of education, language, and literacy.

Social Determinants of Health	
Health and healthcare	Medical problems/illnesses/Hospitalizations/Surgeries/ Infectious Diseases/Gynecological Conditions/ Infertility/ Mental Health disorders/Screening for Depression/ Stress/Substance Use/Violence/Domestic Violence/ Serious accidents/ Disabilities/Access to primary care and health literacy. Physical activity
Neighborhood and built environment	Family and community support, environmental conditions, crime, and violence.

Public Health Emergency or Pandemic when Applicable	
Element	**Standard**
NO SCORE – FOR TRACKING PURPOSES ONLY	
Eligible Age Range	Self-Explanatory
Vaccination Status	Self-Explanatory
Education on Vaccine	Self-Explanatory
Disparity Risk Factors: Black/African American Hispanic/Latino White/non-Hispanic	Self-Explanatory
Immunocompromised /Special Healthcare Needs/Disabilities	Self-Explanatory
Symptoms: Mild/Severe	Self-Explanatory
Exposure to Public Health Emergency/Pandemic	Self-Explanatory
Recent Travel	Self-Explanatory
Referred for Testing	Self-Explanatory
Testing used: Viral Test /Antibody test	Self-Explanatory
Confirmed Illness	Self-Explanatory
Quarantine & Isolation	Self-Explanatory
Hospitalization	Self-Explanatory
Treatment	Self-Explanatory

Cognitive Assessment	
Element	**Standard**
Cognitive Assessment	Evidence that cognitive assessment tools have been used to identify cognitive impairments and determine whether a full dementia evaluation is needed to assess for a possible dementia syndrome. The provider may have used any of the following and other assessment that would help determine cognitive functioning: Mini-Cog Memory Impairment Screen (MIS) General Practitioner Assessment of Cognition (GPCOG) Montreal Cognitive Assessment (MoCA) Saint Louis University Mental Status (SLUMS) Mini-Mental State Examination (MMSE)

Telehealth	
Element	**Standard**
Services rendered using Telehealth:	• Explanation of the use of Telehealth in each progress note. • Provider complying with HIPAA and State and Federal laws pertaining to privacy. • Documented evidence that the enrollee had a choice of whether to access services through a face-to-face or Telehealth encounter. • Telehealth procedures comply with the requirements the Contracts with the State. 45 CFR 164.312, • Evidence that the member signed an authorization to receive service via Telehealth. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided. Copy of this authorization must be in the records. • For Telepsychiatry, the results of the assessment, findings, and partitioner(s) plan for next steps. • Evidence that the provider has implemented protocols to prevent fraud and abuse. • Public Health providers who provide Telehealth have evidence that they have contacted the Plans before providing the health care services to members and evidence that they have provided the Plans with the results of the office visit, including test results. • Documentation of Telehealth equipment used for the covered services provided.

Infection Prevention

For our providers to ensure members are treated in a safe and sanitary environment, you must implement nationally recognized infection control guidelines, such as those through the CDC. The infection prevention program's purpose is to identify and prevent infections and maintain a sanitary practice environment.

Your office staff must be educated on:

- A process for identifying and preventing infections through activities such as proper hand hygiene and safe injection practices.
- A process for the management of identified hazards, potential threats, near misses, and other safety concerns; this includes monitoring of products, including medications, reagents, and solutions that carry an expiration date.
- Being aware of and a process for the reporting of known adverse incidents to the appropriate state and federal agencies when required by law to do so.
- A process to reduce and avoid medication errors.
- Prevention of falls or physical injuries involving patients, staff, and all others.

You must have a written emergency and disaster preparedness plan to address internal and external emergencies to ensure member safety, including an evacuation plan.

You must provide for accessible and available health services, ensuring information about services when provider practices are not open.

Simply and our providers must comply with applicable state and local building codes and regulations; applicable state and local fire prevention regulations, such as the NFPA 1010 Life Safety Code, 2024 edition, published by the National Fire Protection Association, Inc.; and applicable federal regulations.

Provider practice sites must:

- Contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type for each potential type of fire.
- Have prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall.
- Have emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of member and staff, in case of an emergency.
- Have stairwells protected by fire doors when applicable.
- Provide examination rooms, dressing rooms and reception areas that are constructed and maintained in a manner ensuring member privacy during interviews, examinations, treatment, and consultation.
- Operate in a safe and secure manner.
- Have provisions to reasonably accommodate disabled individuals.
- Have provisions to safeguard member privacy, accessibility, and member rights.
- Ensure they have the necessary personnel, equipment, supplies, and procedures to deliver safe care and handle medical and other emergencies that may arise.
- Hold periodic drills and have periodic instruction of all staff in the proper use of safety, emergency, and fire-extinguishing equipment.
- Ensure that staff has been trained on infection control, OSHA, and Universal Precautions.
- Establish a safety program and an emergency disaster plan.

These items will be reviewed during site review for each cycle of credentialing and recredentialing. All items will be scored using the practitioner site office tool.

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.

Our risk management program 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 and employees at the lowest reasonable cost:

- To minimize the incidents of legal claims against the provider of care and/or organization.
- To enhance the quality of care provided to members.
- To control the cost of losses.
- To maintain patient satisfaction with the provider of care and the organization.

The scope of the 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 providers of care, agents, and employees of Simply have the affirmative duty to report adverse or untoward incidents (potential or actual) on an incident report form and to send that report to specific personnel for necessary follow-up.

The activities of the risk manager will contribute to the quality of care and a safer environment for members and employees as well as to reduce the cost of risk to the provider of care and the organization.

These activities are categorized as those directed toward loss prevention (pre-loss) and those for loss reduction (post-loss).

The primary goal of pre-loss 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 through:

- 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 post-loss 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.

Internal Incident Reporting System

All Simply employees are educated on the Internal Incident Reporting System, which establishes the policy and procedure for reporting adverse incidents and includes: the definition of adverse incidents, access to the incident reporting form, appropriate routing, and the required time frame for reporting incidents to the risk manager. Provider input and participation in the QM process further emphasizes the identification of potential risks in the clinical aspects of member care.

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

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

1. Death
2. Brain damage
3. Spinal damage
4. Permanent disfigurement
5. Fracture or dislocation of bones or joints
6. 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
7. Any condition requiring surgical intervention to correct or control
8. Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care

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

Reporting Responsibilities

- All participating and direct service providers are required to report adverse incidents to the Managed Care Plan within 48 hours of the incident for MMA, FHK, and Specialty Plan enrollees. All participating and direct service providers, including home- and community-based services (HCBS) providers, are required to report critical incidents for Long Term Care (LTC) members to Simply within 24 hours of discovery. Reporting will include information on the enrollee's identity, a description of the incident and outcomes, including the current status of the enrollee.
- Simply will immediately report to the Department of Children and Families (DCF) any suspected cases of abuse, neglect, or exploitation of enrollees, in accordance with s.39.201 and Chapter 415, F.S. The Adult and Child Protective Services Program (DCF) has the responsibility for investigating allegations of abuse, neglect, and exploitation of children and vulnerable adults. The Abuse Hotline number is **800-96-ABUSE (800-962-2873)**.
- Additionally, Simply reports any adverse and critical incidents to AHCA monthly.

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. 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.
- All incident reports resulting in serious or potentially serious member harm will be forwarded to the risk manager or risk manager designee immediately.
- Incident reports are logged and date-stamped.
- The National Customer Care department associate is responsible for initiating incident reports for member grievances that relate to an adverse or untoward incident.
- Simply employees refer quality of care and quality of service issues to our QM department. The QM department may solicit information from other departments and/or providers during clinical reviews.
- The QM committee will review all pertinent safety-related reports.
- The QM committee, MAC 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 will be made available to the Agency upon request.
- A member incident report will be kept in a risk management computerized file, and the report 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.
- The risk manager will communicate with department directors and managers to provide follow-up as appropriate.
- The risk manager will follow up on all incidents pertinent to quality to determine causes and possible preventive interventions.
- The risk manager will keep statistical data of incidents for analysis.
- The risk manager will keep incident reports in computerized files for no less than 10 years and longer for audits or litigation as specified elsewhere in the MMA contract:
    - Florida Healthy Kids records will be retained for a period of at least ten years following the term of Simply's Florida Healthy Kids contract with Florida Healthy Kids Corporation, except if an audit is in progress or audit findings are yet unresolved, in which case records will be kept until all tasks are completed.

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, practitioner, 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 procedure revisions.

An incident report is an official record of the 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.

For members in the SMI and HIV/AIDS Specialty Plans, the Plan will initiate a root cause analysis (RCA) within fourteen (14) days following each of the following events involving an enrollee of its Specialty product:

1. Suicide.
2. Victim of Homicide.
3. Baker Act of an enrollee aged twenty-one (21) years or younger.
4. Death of an enrollee within one year of delivery or pregnancy termination.
5. Death of an enrollee within one (1) year of life.
6. Victim of abuse, neglect, or exploitation as defined by Section 415.102, F.S.
7. 7) Sexual battery or altercation requiring medical intervention.
8. Resident elopement for enrollees in assisted care communities, as defined by Section 429.41, F.S.

Credentialing

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 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 healthcare 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 Health Delivery Organizations (HDOs):

- Hospitals
- Home Health 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), 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 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 a 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 a Simply medical director designee, and the vice-chair must be a lead medical officer or a 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 their judgment might otherwise be compromised. A committee member will also disclose if they have 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 used. To learn more about CAQH, visit their website at **CAQH.org**.

Simply will verify those elements related to an applicant's 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 120-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards. The application attestation, including work history verification, must be dated and verified within 180 calendar days prior to the Credentials Committee decision.

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
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.

Health Delivery Organizations
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 programs 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:

A. Must not be currently federally sanctioned, debarred, or excluded from participation in any of the following programs: Medicare, Medicaid, or FEHBP;
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where they provide services to members;
C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to their specialty in which they 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
D. 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:

A. 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.
B. 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.
C. 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.
D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement:

1. 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.

2. 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.

E. 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), 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.

F. 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 their specialty in which they 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 they have 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.

    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 their scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances, and
    b. they 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.

11. 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.
12. No history of or current use of illegal drugs or history of or current substance use disorder.

13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. 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.
15. 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.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. 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;
18. No involuntary terminations from an HMO or PPO.
19. 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 (for example, 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].

4. 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 (for example, 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 their certification has expired, the application will be submitted for individual review.
f. If the NP 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 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:
    i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    ii. 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:
    i. On the credentialing file;
    ii. At presentation to the CC, and
    iii. 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. PAs 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 a 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.

A. General Criteria for HDOs:

1. 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.
2. Valid and current Medicare certification.
3. 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**.
4. Liability insurance acceptable to Simply.
5. 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.

B. 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 Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
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,

Additional Considerations
We encourage those providers who wish to be participating providers for HIV/AIDS Specialty Plan, and who are not credentialed by the American Academy of HIV Medicine (AAHIVM) or recognized by the Florida/Caribbean AIDS Education and Treatment Centers (AETC), to do so and refer them accordingly.

While all providers are required to undergo credentialing, we give particular focus to providers serving in the primary care role for our members with HIV/AIDS. We include an *Education/Training Attestation* for participation as an HIV/AIDS PCP in the credentialing packet, which includes the qualifications described below.

Participation as an HIV/AIDS-designated PCP requires that the provider attest that they meet the criteria to care for our members in one of the following ways:

- Be credentialed as an AAHIVM HIV specialist by the American Academy of HIV Medicine (**aahivm.org**)
- Be board -certified in the field of infectious disease and, if not certified in the past year through the American Board of Medical Specialties, has clinically managed a minimum of 25 patients in the preceding 12 months as well as successfully completed a minimum of 10 hours of continuing medical education (CME) with at least five hours related to antiretroviral therapy in the past year
- Be recognized by the Florida/Caribbean AIDS Education and Training Center as having sufficient clinical experience and additional ongoing training in HIV/AIDS to be considered a specialist.

Delegated Credentialing
We will ensure the quality of our credentialing program through direct verification and through delegation of credentialing functions to qualified provider organizations. Where a provider group is believed to have a strong credentialing program, we may evaluate a delegation of credentialing and recredentialing. The provider group must have a minimum of 100 in scope practitioners.

The Enterprise Delegation Oversight & Management department will review the prospective delegate's written credentialing policies and a randomized sample of practitioner files to ensure compliance with contractual, state and federal, as well as NCQA standards. Steps, if any, are identified where the group's credentialing policy does not meet the Simply standards. We will perform or arrange for the group to perform the Simply credentialing steps not addressed by the group.

We will perform a pre-delegation audit of the group's credentialing program:

- A compliant score is between 95 percent and 100%. If the potential delegate has a compliant status and approved by the regional Credentialing Committee, they will be added to the annual audit schedule no more than 12 months from the pre-delegation date.
- A partial compliance score is between 80% and 94%. If the potential delegate has a partial compliance score and approved by the regional Credentialing Committee, any identified deficiencies will be tracked to closure via a corrective action plan (CAP). If the delegate contract is not executed within six months of the pre-delegation audit, the delegate must submit a new pre-delegation audit request.
- If the delegate scores below 80% and denied by the regional Credentialing Committee, the audit is considered a fail. The delegate can submit for reconsideration after a waiting period of six months from the pre-delegation audit date. When a final delegation decision has been made, notice of the audit findings and, if applicable, corrective action plan (CAP) request will be provided to the prospective delegate.

The group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results and monitored monthly. The CAP must be acceptable to Simply and completed within the mutually agreed upon time frame but not to exceed 90 days of the submission.

If there are serious deficiencies, we will recommend the regional Credentialing Committee deny the delegation. Simply is responsible for oversight of any delegated credentialing arrangement and schedules appropriate reviews. The reviews are held annually at a minimum.

Provider Temporary Enrollment

Providers who 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.

Peer Review

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are to:

- Participate in the implementation of the established peer review system, which reviews a provider's practice methods and patterns, morbidity and mortality rates, and all grievances filed relating to medical treatment.
- Evaluate the appropriateness of the care rendered and implement corrective action if needed.
- Review and make recommendations regarding individual provider peer -review cases.
- Work in accordance with the executive medical director.

Should investigation of a member grievance or complaint result in concern about a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the Peer Review Committee (PRC). The medical director informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the QM committee.

Simply has a peer review committee, which has the following responsibilities:

- Evaluating the appropriateness of care rendered by our contracted providers
- Reviewing provider's practice methods and patterns
- Evaluating provider performance, trends in quality of care and service issues
- Developing and analyzing plan wide audits.

If the medical advisory committee cannot convene, the peer review committee may also serve as the Simply's provider advisory council, providing input and recommendations to the plan about clinical guidelines, QM trilogy documents, credentialing reports, PIPS, process improvements, quality indicators, performance measures, HEDIS, and provider satisfaction survey tools and results.

The peer review policy is available upon request.

Quality Measurement Standards for Providers and Requirements for Exchange of Data
Simply Medicaid, Specialty Plans, and FHK contract with an NCQA-certified software vendor, which produces eligible populations, analyzes compliance/noncompliance, and reports rates, including but not limited to the following measures:

Measure Indicator	Description
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
AAP	Adults' Access to Preventive/Ambulatory Health Services
AIS-E	Adult Immunization Status
AMR	Asthma Medication Ratio
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
BPD	Blood Pressure Control for Patients with Diabetes
BCS	Breast Cancer Screening
CCS	Cervical Cancer Screening
WCV	Child and Adolescent Well Care Visits
CIS	Childhood Immunization Status
CHL	Chlamydia Screening in Women
COL	Colorectal Cancer Screening
CBP	Controlling High Blood Pressure
DSF-E	Depression Screening and Follow-up for Adolescents and Adults
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
EED	Eye Exam for Patients with Diabetes
FUA	Follow-up after Emergency Department Visit for Substance Use
FUM	Follow-up after Emergency Department Visit for Mental Illness
FUH	Follow-up after Hospitalization for Mental Illness

Measure Indicator	Description
GSD	Glycemic Status Assessment for Patients with Diabetes
ADD	Follow-up Care for Children Prescribed ADHD Medication
IMA	Immunizations for Adolescents
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
KED	Kidney Health Evaluation for Patients with Diabetes
PPC	Prenatal and Postpartum Care
PDS-E	Postpartum Depression Screening and Follow-up
PND-E	Prenatal Depression Screening and Follow-up
PRS-E	Prenatal Immunization Status
SNS-E	Social Need Screening and Intervention
SPC/SPD	Statin Therapy for Patients with Cardiovascular Disease and Diabetes
ASF-E	Unhealthy Alcohol Use Screening and Follow-up
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
W30	Well-Child Visits in the First 30 Months of Life
LSC	Lead Screening in Children
Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)	
COB-AD	Concurrent Use of Opioids and Benzodiazepines
CCW-AD	Contraceptive Care – All Women Ages 21 to 44
CCP-AD	Contraceptive Care – Postpartum Women Ages 21 to 44
HPCMI-AD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)
HVL-AD	HIV Viral Load Suppression
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
CDF-AD	Screening for Depression and Follow-up Plan
OHD-AD	Use of Opioids at High Dosage in Persons without Cancer
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder
Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)	
CCW-CH	Contraceptive Care – All Women Ages 15 to 20
CCP-CH	Contraceptive Care – Postpartum Women Ages 15 to 20

Measure Indicator	Description
DEV-CH	Developmental Screening in the First Three Years of Life
CDF-CH	Screening for Depression and Follow-up Plan
Other Measures	
FP-02	Pregnancies Conceived within 18 Months of a Previous Birth
SMI SPECIALTY PRODUCT - SPECIFIC PERFORMANCE MEASURE REQUIREMENTS	
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia
SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
CMS Electronic Clinical Quality Measures	
BMD	Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use
HEALTH RESOURCES AND SERVICES ADMINISTRATION – RYAN WHITE HIV/AIDS PROGRAM PERFORMANCE MEASURES	
Prescription of HIV Antiretroviral Therapy	
HIV Medical Visit Frequency	
AGENCY-CALCULATED PERFORMANCE MEASURES	
Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)	
LBW-CH	Live Births Weighing Less than 2,500 Grams
LRCD-CH	Low-Risk Cesarean Delivery
Solventum Potentially Preventable Events (PPEs)	
PPAs	Potentially Preventable Admissions
PPRs	Potentially Preventable Readmissions
PPVs	Potentially Preventable Emergency Department Visits

10 MEMBER APPEAL AND GRIEVANCE PROCEDURES

Overview

Simply has a formal appeal and grievance process to handle disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see the **Provider Payment Disputes** section.

The appeal process is the procedure for addressing member appeals, which are requests for review of an adverse benefit determination. Adverse benefit determinations are defined as the following:

- The denial or limited authorization of a requested service, including the type or level of service pursuant to *42 CFR 438 400(b)*
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or part, of a payment for a service
- The failure to provide services in a timely manner as defined by the state
- The failure of the plan to act within the time frames provided in *Sec. 438.408(b)*

Members have the right to tell Simply if they are not happy with their care or the coverage of their healthcare needs by calling Member Services Monday to Friday, 8 a.m. to 7 p.m. ET. These are called grievances and appeals:

- 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.
- An **appeal** is a formal request from a member to seek a review of an adverse benefit determination made by Simply.

Complaints and Grievances

Simply has a process to solve complaints and grievances. If a member has a concern that is easy to solve and can be resolved within 24 hours, Member Services can help. If the concern cannot be handled within 24 hours and needs to be looked at by our grievance coordinator, the concern is noted and turned over to the grievance coordinator.

A complaint or grievance must be given orally or in writing any time after the event happened.

To file a complaint or grievance, the member can call Member Services at **844-406-2396** (TTY **711**) and FHK members can call Member Services at **844-405-4298,** Monday to Friday between 8 a.m. and 7 p.m. ET, or write us a letter regarding the concern and mail it to:

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

Members can have someone else help them with the grievance process. This person can be:

- A family member.
- A friend.
- A doctor.
- A lawyer.

The member must give written permission in order for someone else to file a grievance or an appeal on their behalf.

If a member needs help filing the complaint, Simply can help. They can call Member Services at **844-406-2396** (TTY **711**) and FHK members can call Member Services at **844-405-4298**.

If the member or member's representative would like to speak with the grievance coordinator to give more information, they should tell Member Services when the complaint is filed or put it in a letter.

Once Simply gets the grievance (oral or written), we send the member a letter within five business days, telling them the date we received the grievance.

What happens next?

1. The grievance coordinator reviews the concern.
2. If more information is needed or you have asked to talk to the coordinator, the coordinator will call the member or the designated representative.
3. If you have more information to give us, you can bring it to us in person or mail it to:
   Simply Healthcare Plans, Inc.
   Grievance Coordinator
   P.O. Box 62429
   Virginia Beach, VA 23466-2429
4. Medical concerns are looked at by medical staff.
5. Simply will tell the member the decision of the grievance within 30 calendar days from the date we received the grievance.

Medical Appeals

There may be times when Simply says it will not pay, in whole or in part, for care that a member's doctor recommended. If we do this, a member or someone on behalf of a member (with the member's written consent) can appeal the decision. A medical appeal is when Simply is asked to look again at the care being asked for that we said we will not pay for. Members must file for an appeal within 60 days from the date on the letter that says Simply has denied, limited, reduced, suspended, or terminated services. Simply will not hold it against the member or the doctor for filling an appeal.

The member can have someone else help them with the appeal process. This person can be a family member, friend, doctor, or lawyer. Write this person's name on the appeal form and fill out a request to designate a personal representative form.

Members can ask us to send you more information to help them understand why we would not pay for the service you requested.

I want to ask for an appeal. How do I do it?

An appeal may be filed verbally or in writing within 60 calendar days of the date on the notice of adverse benefit determination.

There are four ways to file an appeal:

1. Write us and ask to appeal.
2. Call Member Services at **844-406-2396, or FHK members can call 844-405-4298** (TTY **711**).
3. Send a fax to **866-216-3482**.
4. Email us at flmedicaidgrievances@simplyhealthcareplans.com.

What else do I need to know?

If the member wants someone else to help with the appeal process, let us know, and we will send the member a form for that.

When Simply receives an appeal, we will send the member a letter within five business days notifying them of the receipt of the appeal request.

Members may ask for a free copy of the guidelines, records, or other information used to make the denial and/or appeal decision.

We will notify the member of the decision within 30 calendar days of getting the appeal request. If we reduce coverage for a service an MMA member is receiving and the member wants to continue to get the service during the appeal, the member can call Simply to ask for continuation of benefits. The member must call within 10 days of the date of the initial denial letter that tells them Simply will not pay for the service.

FHK members are not eligible for continuation of benefits during the appeal process.

If you or the member has more information to give us, you can bring it in person or mail it to the address below. Also, the member can look at medical records and information on this decision before and during the appeal process.

The time frame for an appeal 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 appeal 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 appeal.

Please call Simply Member Services at **844-406-2396,** and FHK can call **at 844-405-4298** (TTY **711**), Monday to Friday, 8 a.m. to 7 p.m. ET.

Where do I mail my letter?
Mail all medical information and medical necessity appeals to:

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

What can I do if Simply still will not pay?
The member, or representative on the member's behalf with the member's written consent, has a right to ask for a state fair hearing. Members must complete the appeal process before requesting a Medicaid fair hearing. If the member would like to request a fair hearing, they must do so no later than 120 calendar days from the date of the notice of plan appeal resolution letter. **Members may be required to pay the cost of services provided while the appeal or State Fair Hearing is pending.**

The Medicaid Hearing Unit is not part of Simply. They look at appeals of Medicaid members who live in Florida. If you contact the Medicaid Hearing Unit, we will give them information about your case, including the information you have given us.

Members have the right to ask to receive benefits while the hearing is pending. To do so, they can call Member Services toll free at **844-406-2396.** (TTY **711**).

Note: Members cannot ask for a Medicaid fair hearing if they have MediKids or FHK. FHK members should request an IRO (Independent Review) by writing to us or emailing us at flmedicaidgrievances@simplyhealthcareplans.com.

How do I contact the state for a state fair hearing?
You 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

What can I do if I think I need an urgent or expedited appeal?
Members can ask for an urgent or expedited appeal if they or their physician think the time frame for a standard appeal process could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

Members can also ask for an expedited appeal by calling Member Services toll free at **844-406-2396 or FHK at 844-405-4298** (TTY **711**), Monday to Friday, 8 a.m. to 7 p.m. ET.

We must respond to the expedited request within 48 hours after we receive the appeal request, whether the appeal was made verbally or in writing. For FHK members, we must respond to the expedited request within 72 hours after we receive the appeal request, whether the appeal was made verbally or in writing.

If the request for an expedited appeal is denied, the appeal will be transferred to the time frame for standard resolution, and the member will be notified orally by close of business on the same day and a written notice will be sent within two calendar days.

If you have any questions or need help, please call Member Services toll free at **844-406-2396** or FHK members at **844-405-4298** (TTY **711**), Monday to Friday, 8 a.m. to 7 p.m. ET.

11 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Electronic Submission

Simply encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within 180 days from the date of discharge for inpatient services or from the date of service for outpatient services.

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.

Availity EDI Payer IDs

Payer IDs ensure your EDI submissions are routed correctly when received by Availity.

Simply = SMPLY
HIV/AIDS Plan = CLEAR

Note: If you use a clearinghouse, billing service, or vendor, please work with them directly to determine the payer ID.

Availity's EDI submission Options:

- EDI Clearinghouse for Direct Submitters (may require practice management or revenue cycle software). To register for direct EDI transmissions, visit **Availity Essentials** > My Account Dashboard > EDI Companion Guide.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway)

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)

Electronic Remittance Advice (ERA)

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 **Essentials.Availity.com — essentials.availity.com/static/public/onb/onboarding-ui-apps/availity-fr-ui/#/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.

Electronic Funds Transfer (EFT)
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 three days after the EFT payment date once the claim is adjudicated.

EDI Submission for Corrected Claims
For corrected electronic claims the following frequency code:

- 7 – Replacement of Prior 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.

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, Billing Vendor, or Availity at **800-AVAILITY (800-282-4548)**.

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

Useful EDI Documentation

Availity EDI Connection Service Startup Guide — This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
Availity EDI Companion Guide — This Availity EDI Guide supplements the *HIPAA* TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
Availity Registration Page — Availity register page for users new to Availity.
Washington Publishing Company — X12 code descriptions used on EDI transactions.

Paper Claims Submission

Providers also have the option of submitting paper claims. Simply uses optical character reading (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Simply staff for claims information, allowing 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) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed *CMS-1450* or *CMS-1500 (08-05)* within 180 days from the date of discharge for inpatient

services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim.

Paper claims must be submitted **within 180 days** of the date of service and submitted to the following address:

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

Encounter Data

Simply maintains 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 Simply for each member encounter. Encounter data can be submitted through EDI submission methods or on a *CMS-1500 (08-05)* claim form unless other arrangements are approved by Simply. Data will be submitted in a timely manner, but no later than 180 days from the date of service.

Encounter data should be submitted to the following address:

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

Through claims and encounter data submissions, HEDIS information is collected. This includes but is not limited to:

- Preventive services (for example, childhood immunization, mammography, Pap smears).
- Prenatal care (for example, LBW, general first-trimester care).
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders).

Compliance is monitored by the Simply utilization and quality improvement staff, coordinated with the medical director and reported to the quality management committee on a quarterly basis. The primary care provider (PCP) is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination from the network.

Medical Attachments

Submit your documentation using the following methods:

- Locate your claim using Availity Essentials Claim Status by navigating to Claims & Payments > Claim Status > Select Attachment button and upload your documents. You can view the status of the attachment by navigating to Claims & Payments > Attachment - New.
- Submit attachment using the EDI 275 transaction.
- Submit an online claim submission using Availity Essentials. Navigate to Claims & Payments > Select Claims & Encounters > Enter claim and upload your attachment.

Submit a PWK segment with your electronic claim navigate to **Essentials.Availity.com** > Claim & Payments > Claims > Attachment - New. Locate your PWK intake in the Attachment Dashboard inbox and upload your documentation. The PWK inbox notification will be available for 7 calendar days.

Claims Adjudication

Simply is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims that are submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD manuals. Institutional claims should be submitted using EDI submission methods or a *UB-04 CMS-1450* or successor forms; provider services should be submitted using the *CMS-1500*.

Providers must use *HIPAA*-compliant billing codes when billing Simply. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Simply will not pay any claims submitted using noncompliant billing codes. Simply reserves the right to use code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure.

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within 180 days from the date the service is rendered; for inpatient claims filed by a hospital, submit claims within 180 days from the date of discharge unless contract timeframes state otherwise.
- In the case of other insurance (crossover claim submission), the claim must be received within 90 days of receiving a response from the primary payer's determination or three years for Medicare crossover claims.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 180 days from the date the eligibility is added and Simply is notified of the eligibility/enrollment. Claims submitted after the 180-day filing deadline will be denied.

After filing a claim with Simply, review the *Explanation of Payment* (*EOP*). If the claim does not appear on an *EOP* within 30 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim at **Essentials.Availity.com** or through the automated Provider Services line at **844-405-4296**. If the claim is not on file with Simply, resubmit your claim within 180 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

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.

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
- Requires no further information, adjustment, or alteration by the provider or by a third party in order to be processed and paid by Simply

We produce and mail an *EOP* Monday through Saturday, 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.

In accordance with state requirements, we will pay at least 90% of all clean claims from practitioners, either in individual or group practice, or who practice in shared health facilities, within 30 days of the date of receipt. We will pay at least 99% of all clean claims from practitioners, either in individual or group practice, or who practice in shared health facilities, within 90 days of the date of receipt. The date of receipt is the date Simply receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

Claims Status

You can visit the provider website or call the automated Provider Services line at **844-405-4296** to check claims status.

High dollar claims may be placed in a prepayment pending status to enable third-party vendor claims review. An itemized bill may be requested for claims review, only if otherwise indicated in your contract.

Providers can confirm the status and payment detail of their claims by logging in to **Availity Essentials** with their username and password. When viewing the status of a claim on Availity Essentials, there may be options available to submit medical records or an itemized bill or dispute the claim.

From the Availity Essentials home page, select Claims & Payments > Claim Status.

Provider Reimbursement

Increased Medicaid Payments for Primary Care Physicians and Eligible Providers

In compliance with the Patient Protection and Affordable Care Act (PPACA), as amended by Section 1202 of the Health Care and Education Reconciliation Act, Simply reimburses eligible Medicaid primary care providers (PCPs) at parity with Medicare rates for qualified services in calendar years 2013 and 2014.

If you meet the requirements for the PPACA enhanced physician reimbursement and haven't yet submitted a completed attestation, you should do so as soon as possible to qualify for enhanced payments. Visit the provider website for links to information and instructions.

Simply Process for Supporting Enhanced Payments to Eligible Providers
As set forth in "Section 1202" of the PPACA:

- Conditioned upon the state of Florida requiring and providing funding to Simply, Simply will provide increased reimbursement to Medicare levels or some other federal or state-mandated level for specified CPT-4 codes for primary care services furnished with dates of service in 2013 and 2014 by providers who have attested to their eligibility to receive such increased reimbursement as set forth in "Section 1202" of the PPACA.
- Such CPT-4 codes will be paid in accordance with the requirements of PPACA, and the state, and will not be subject to any further enhancements from Simply or any other source.

Provider Responsibilities with Regard to Payments
If you completed the attestation process as required by the state, the following procedures and guidelines apply to you regarding payments received from Simply:

- If you are a group provider, entity, or any person other than the eligible provider who performed the service, you acknowledge and agree you will direct any and all increased reimbursements to such eligible providers or otherwise ensure such eligible providers receive direct and full benefit of the increased reimbursement in accordance with the final rule implementing PPACA.
- You also acknowledge and agree you will provide Simply with evidence of your compliance with this requirement upon request.

Maternity Coverage, Billing, Reimbursement Policies
Effective **January 1, 2022**, Simply Healthcare Plans will no longer reimburse postpartum visit Current Procedural Terminology (CPT) Code, 59430, Postpartum care only, if billed in conjunction with a global or bundled billed CPT code.

- If CPT code "**59430**" is billed after a delivery claim using "**59400, 59510, 59610, 59618, 59410, 59515, 59614",** then "**59430**" should be denied.

Also, effective **January 1, 2022**, Simply Healthcare Plans will begin down-coding all bundled payments to delivery service only CPT codes if the postpartum CPT Category II Code (Table 1.2) is not submitted within timely filling (180 days) to verify postpartum visit completion:

- If cat II code "**0503F**" for postpartum visit is not submitted within 270 days (90 days postpartum window and 180 days timely filling) after the DOS on bundled delivery claims CPT codes "**59410, 59515, 59614"** then they should be down coded to the corresponding delivery service only code:
    - **59409 to 59410** *Vaginal delivery only (with or without episiotomy and/or forceps)*
    - **59510 to 59514** *Cesarean delivery only*
    - **59612 to 59614** *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)*

** Exception: when submitting bundle bill CPT code, 59622, provider's may also bill up to three postpartum visits (CPT code 59430) within 90 days following delivery, as delivery services only CPT code, 59620 -cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, is not on the 2021 AHCA practitioner fee schedule (Florida Agency For Health Care Administration, 2021).*

Routine inpatient Hospital postpartum CPT codes "**99231**, **99232**, **99238"** that have an ICD-10 diagnosis code of "**Z39.2** - routine postpartum follow-up" should be denied if provider billed a global/bundle CPT codes "**59400, 59510, 59610, 59618, 59410, 59515, 59614"** for the delivery**.**

PCP Reimbursement

Simply reimburses PCPs according to their contractual arrangement.

Specialist Reimbursement
Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Simply.

Specialty care providers will obtain PCP and Simply approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP's referral or beyond the scope of self-referral permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification and receipt of the required claims and encounter information to Simply.

Overpayment Process
Refund notifications may be identified by two entities: 1) Simply and its contracted vendors or 2) the providers.

Once an overpayment has been identified by Simply, Simply will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment. Providers have up to 60 days to dispute an overpayment. If a refund check is not received, the identified overpayment will offset against future claims payments. Notification of overpayment will be submitted to facility claims within 30 months and to physician claims within 12 months.

The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount. 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 is located on the provider website. The submission of the Refund Notification Form will allow us to process and reconcile the overpayment in a timely manner. 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

For questions regarding the refund notification procedure, please call Provider Services at **844-405-4296** and select the appropriate prompt. 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.

Cost Containment Overpayment Disputes
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 or by mail or fax to:

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 being refunded, and the refund amount to be applied to each claim to:

Cost Containment
PO Box 933657
Atlanta, GA 31193-3657

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, Simply will notify the provider of the overpayment, then commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

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.

What does this mean for you?
The provision directly 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 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 Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at *42 U.S.C.A. § 1320a-7k*, 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, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Reimbursement Policies
These reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if Simply covered the service is for a member's benefit plan. The determination that a service, procedure, item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Simply may:
- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

The reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Simply strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Reimbursement Hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered conditions of payments.

Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Simply business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently through Simply. Those guidelines include, but are not limited to:
- Correct modifier use
- Effective date of transaction code sets (for example, CPT, HCPCS, ICD diagnosis/procedures, revenue codes)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition, and appropriate use

Reimbursement by Code Definition
Simply allows reimbursement for covered services based on their procedure code definitions or descriptor, as opposed to their appearance under particular CPT categories or sections, or descriptors unless otherwise noted

by state or provider contracts or state, federal or CMS contracts and/or requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services, or procedures

Outlier Reimbursement - Audit and Review Process

Requirements and Policies

This section includes guidelines on reimbursement to providers and facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests

At any time, a request may be made for on-site, electronic, or hard copy medical records, utilization review documentation and/or itemized bills related to claims for the purposes of conducting audit or reviews.

Blood and Blood Products

Blood and blood products, such as platelets or plasma, are reimbursable. Administration of Blood or Blood Products by nursing/facility personnel is not separately reimbursable on inpatient claims. Administration of blood or blood products by nursing/facility personnel billed on outpatient claims is separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation, such as thawing, splitting, pooling, and irradiation, are also not separately reimbursable. Lab tests such as typing, Rh, and matching are separately reimbursable charges.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supplies, time, and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services. See Facility Personnel Charges and Nursing Procedures sections for additional information.

Facility Personnel Charges

Charges for Inpatient Services for facility personnel are not separately reimbursable, and the reimbursement for such is included in the room and board rate or procedure charge. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), therapeutic, prophylactic, or diagnostic intravenous (IV) injections or infusion or IV fluid administration/monitoring, call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services, and chemotherapy infusion/administration/monitoring. Charges

for Outpatient Services for facility personnel are also not separately reimbursable and are included in the reimbursement for the procedure or observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors, and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices, and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the member will not be reimbursed.

IV sedation and local anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges
The reimbursement of charges for specimen collection is considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor Care Charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures
Fees associated with nursing procedures or services provided by facility nursing staff or unlicensed facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited, to therapeutic, prophylactic, or diagnostic intravenous ("IV") injections or infusion or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time) and inpatient blood transfusion administration/monitoring and inpatient chemotherapy infusion/administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating Room Time and Procedure Charges
The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as

documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary, and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

Personal Care Items and Services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste.

Pharmacy Charges

Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges

Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

Preparation (Set-Up) Charges

Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during their confinement. This will include, but is not limited to, cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room services related to IV sedation and/or local anesthesia

Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II or step-down recovery room (for example, arteriograms).

Respiratory Services
Mechanical ventilation/CPAP/BIPAP support and other respiratory and pulmonary function services provided at the bedside are considered facility personnel, equipment, and/or supply charges and not eligible for separate reimbursement.

Routine Supplies
Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and supplies and not separately reimbursable in the inpatient and outpatient environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

Special Procedure Room Charge
Charges for Special procedure room, billed in addition to the procedure itself, are included in the reimbursement for the procedure. If the procedure takes place outside of the OR (Refer to Operating Room Time and Procedure Charges for OR definition), then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: procedures performed in the ICU, ER.

Stand-by Charges
Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies are not separately reimbursable. Oxygen charges, including but not limited to, oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area are not separately reimbursable.

Tech Support Charges
Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, is not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation
- **Operating Room ("OR")** –Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/ Technical Anesthesia** - Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.

- **Recovery Room** – The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- **Post Recovery Room** – Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Undocumented or Unsupported Charges
Charges that are not documented on medical records or supported with documentation are not reimbursed.

Video or Digital Equipment used in Procedures
Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but are not limited to Ultrasound and Fluoroscopy guidance including but not limited to, for access and/or placement of medical devices, implants, or lines. Charges for batteries, covers, film, anti-fogger solution, tapes are also not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges
For any claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Procedures

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0270, 0271, 0272	• Supplies and Equipment • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes; • Wipes (baby, cleansing) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls; Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels, and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets) • Preps/prep trays • Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• OR Equipment (saws, skin staplers, staples and staple removers, sutures, scalpels, blades) • IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, heparin, and saline flushes)
0220 – 0222, 0229, 0250	• Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge portable fee unless equipment is brought in from another facility) • Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER), Post Anesthesia Care Unit (PACU), or Operating Room (OR)
0250 – 0259, 0636	Pharmacy • Medication prep • Nonspecific descriptions • Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges • IV Solutions 250 cc or less, except for pediatric claims • Miscellaneous Descriptions • Compounding fees

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	• Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration • Thawing/Pooling Fees
0270, 0272, 0300 – 0309	• Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment • Oxygen (ICU/CCU/Progressive) O.R., ER, and Recovery • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heel/Elbow Protector • Burrs • Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies • Case Carts • C-Arm/Fluoroscopic Charge

Examples of non-reimbursable items/services codes (including but not limited to):	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (specifically, conscious/moderate sedation by same physician or procedure nurse) • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia if provided by same physician or procedure nurse • Intubation/Extubation • CPR
0410	Nursing Respiratory Functions: • Oximetry • Vent management • Medication Administration via Nebs, Metered dose (MDI) • Postural Drainage • Suctioning Procedure
0940 – 0945	Education/Training

Following the change made to F.A.C., 59G-1.050, Section (7) Gender Dysphoria, the Agency for Health Care Administration (AHCA) determined that Florida Medicaid does not cover puberty blockers, hormones, hormone antagonists, sex reassignment surgeries, or any other procedure that alters primary or secondary sexual characteristics for the treatment or management of gender dysphoria. Likewise, the FHK program also determined that these services are not covered benefits for gender dysphoria. Because these services are not a covered benefit, your Simply and/or FHK patients/members with gender dysphoria who receive their care under Florida Medicaid or Florida Healthy Kids will be denied medications and requests for services related to gender dysphoria. In addition, any and all claims for these non-covered services will not be paid.

Claim Payment Disputes

Provider Claim Payment Dispute Process

If you disagree with the outcome of a claim, you may begin the Simply provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

Please be aware there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- Claim inquiry: a question about a claim but not a request to change a claim payment
- Claims correspondence: when Simply requests further information to finalize a claim; typically includes medical records, itemized bills, or information about other insurance a member may have
- Medical necessity appeals: a pre-service appeal for a denied service; for these, a claim has not yet been submitted

For more information on each of these, please refer to the appropriate section in this provider manual.

The Simply provider payment dispute process consists of two internal steps and/or a third external step alternative. You will **not** be penalized for filing a claim payment dispute, and no action is required by the member:

1. **Claim payment reconsideration:** This is the first step in the Simply provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. **Claim payment appeal:** This is the second step in the Simply provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. **Regulatory complaint:** Providers have the option to use the state arbitration process and do not need to exhaust the aforementioned plan processes prior to requesting an external review.

A claim payment dispute may be submitted for multiple reason(s), including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim Payment Reconsideration

The first step in the Simply claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally, and through our secure provider website within 90 days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 90 days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, the appropriate clinical Simply professionals will review it.

Simply will resolve the claims payment reconsideration within 60 calendar days of receipt. We will provide written notice of the status of the reconsideration every 30 days.

We will send you our decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Simply intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- An explanation of the provider's right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter.
- An address to submit the claim payment appeal.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim Payment Appeal

If you are dissatisfied with the outcome of a reconsideration determination you may submit a claim payment appeal. Please note, we cannot process a claim payment appeal without a reconsideration on file.

We accept claim payment appeals through our provider website or in writing within 30 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 30 calendar days after the claims reconsideration determination letter will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Simply professionals.

Simply will resolve the claim payment appeal within 60 calendar days of receipt. We will provide written notice of the status of the claim payment appeal every 30 days.

We will send you our decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Simply intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to Submit a Claim Payment Dispute
We have several options to file a claim payment dispute:

- Preferred method — **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at **Essentials.Availity.com**. Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission.
- Verbally (for reconsiderations only): Call Provider Services at **844-405-4296**.
- Written (for claim payment appeals only): Mail all required documentation (see below for more details), including the Claim Payment Appeal Form or the Reconsideration Form, to:

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

Submit written claim payment appeals on the form Claim Payment Appeal Form, located in Appendix A of this manual.

If a provider is dissatisfied with the claim payment appeal resolution, the provider may appeal the Simply decision to Capitol Bridge (the vendor for AHCA 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.

Required Documentation for Claims Payment Disputes
Simply requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Simply or Medicaid ID number
- A listing of disputed claims, which should include the Simply claim number and the date(s) of service(s)
- All supporting statements and documentation

Claim Inquiries

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call **844-405-4296** and select the *Claims* prompt within our voice portal. 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.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Providers can confirm the status and payment detail of their claims by logging in to **Availity Essentials** with their username and password. When viewing the status of a claim on Availity Essentials, there may be options

available to submit medical records or an itemized bill or dispute the claim. If there has been no response to a submitted claim after 30 business days from the date the claim was submitted, providers can initiate follow-up action to determine the claim status.

From the Availity Essentials home page, select Claims & Payments > Claim Status. Providers can also access Chat with Payer through Claim Status or Availity Payer Spaces.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when Simply requires more information to finalize a claim. Typically, Simply makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Simply will use it to finalize the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of issue	What do I need to do?
EDI rejected claim(s)	View your electronic response reports for rejections. Contact Availity Client Services at **800-Availity (800-282-4548)**. Availity Client Services is available Monday to Friday 8 a.m. to 8 p.m. ET. Work with your EDI vendor or Clearinghouse.
EOP requests for supporting documentation (sterilization/hysterectomy/abortion consent forms, itemized bills, and invoices)	Submit a Claim Correspondence Form, a copy of your EOP, and the supporting documentation to: 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: 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: 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. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Simply to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI EOB. Submit a corrected claim using EDI For corrected electronic claims, the following frequency code: • 7 – Replacement of Prior 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. Submit a corrected claim on Availity Essentials. Navigate to Claims & Payments > Claims & Encounters. Enter new claims and choose “7” as the frequency code and use the “original claim number” as the Payer Claim Control Number.
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: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency room payment review	Submit a Claim Correspondence Form, a copy of your EOP, and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Medical Necessity Appeals

Medical necessity appeals refer to a situation in which an authorization for a service was denied prior to the service. Medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the medical necessity appeal process.

Coordination of Benefits

State-specific guidelines will be followed when coordination of benefits (COB) procedures are necessary. Simply agrees to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in the Simply plan.

Simply and our providers agree the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When Simply is aware of these resources prior to paying for a medical service, we will avoid payment by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Simply does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post-payment recovery of the expenditure. Providers must **not** seek recovery in excess of the Medicaid payable amount.

Simply will avoid payment of trauma-related claims where third-party resources are identified prior to payment. Otherwise, we will follow a pay-and-pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post payment to determine likely cases with multiple letters and phone calls being made to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor, ACS Recovery Services.

We will require members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied, or pended claims should be directed to Provider Services at **844-405-4296**.

Billing Members

Overview

Before rendering services, providers should always inform members that the cost of services not covered by Simply will be charged to the member.

A provider who chooses to provide services **not covered** by Simply:

- Understands Simply only reimburses for medically necessary services, including hospital admissions and other services.
- Obtains the member's signature on the client acknowledgment statement, which specifies the member will be held responsible for payment of services.
- Understands they may not bill or take recourse against a member for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the Medicaid program.

Simply members must not be balance-billed for the amount above that which is paid by Simply for covered services.

In addition, providers may **not** bill a member if any of the following occurs:

- Failure to submit a claim timely, including claims not received by Simply
- Failure to submit a claim to Simply for initial processing within the six-month filing deadline
- Failure to submit a corrected claim within the 180-day filing resubmission period
- Failure to appeal a claim within the 90-day administrative appeal period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial

- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission, or the appeal process

Client Acknowledgment Statement
A provider may bill a Simply member for a service that has been denied as not medically necessary or not a covered benefit **only if** both of the following conditions are met:

- The member requests the specific service or item
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Simply as being reasonable and medically necessary for my care or may not be a covered benefit. I understand that Simply has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Simply medically necessary standards for my care or are not a covered benefit."

Signature: _____

Date: _____

Accessing Claim Status, Member Eligibility, and Authorization Determinations

Simply recognizes that for you to provide the best service to our members, we must share with you accurate, up-to-date information. To access claim status, member eligibility, and authorization determination (24 hours a day, 365 days a year):

- Access **Essentials.Availity.com**, your exclusive, secure multi-payer portal to access real-time- claim status, eligibility verification, and precertification status. You can also submit a claim, precertification, or obtain a member panel listing. Detailed instructions for use of the provider online reporting tool are located on the provider website.
- Call the toll-free, automated Provider Services line at **844-405-4296** for real-time member status, claim status and precertification status. This option also offers the ability to be transferred to the appropriate department for other needs, such as seeking advice in case/care management.

APPENDIX A: FORMS

The following forms are available on the provider website. You may download them for your use as needed.

Referral and Claim Submission Forms:

- Authorization Request Form
- Maternity Notification Form
- Child Health Check-Up 221 Form and Claim Instructions — This form and instructions are available at **fdhc.state.fl.us/medicaid** or by calling **800-289-7799**
- Specialist as a PCP Request Form
- CMS1500 (0805) Claim Form
- UB04 Claim Form

Precertification Forms:

- Precertification Information Required for Hysterectomy
- Precertification Information Required for Gastroplasty
- Precertification Information Required for Tonsillectomy, Adenoidectomy, Adenotonsillectomy

Provider Grievances and Appeals Forms:

- Provider Payment Dispute and Correspondence Submission
- Provider Medical Necessity Appeal Form
- Grievance Form

Medical Record Documentation Forms:

- Adult Health Form
- Oral Lead Risk Form – English
- Oral Lead Risk Form – Spanish
- Incident Report Form
- Inpatient Medical Review Form
- Advance Directive – English
- Advance Directive – Spanish
- Durable Power of Attorney – English/Spanish
- Living Will – English/Spanish
- Site Review Form

Other Forms:

- Florida Assisted Living Facility Form
- Authorization Request Form
- Pharmacy Prior Authorization Form
- Medical Injectable Prior Authorization Form
- Incident Report Form
- Sterilization Consent Form
- Hysterectomy Acknowledgement Form
- Provider Payment Dispute Form

Behavioral Health Forms:

- Alzheimer's Mini-Cog Screening
- ASSIST SUD Screening
- AUDIT Alcohol Use Questionnaire

- CRAFFT Adolescent SUD Screening
- Functional Activities Questionnaire
- Michigan Alcohol Screening Test (MAST)
- Mood Disorder Questionnaire Bipolar Disorder Screening
- Pediatric Symptom Checklist
- PHQ-9 Depression Screening
- Vanderbilt Assessment Scales ADHD Screening
- Tip Sheet: PCP Toolkit & Telehealth Resource

Hysterectomy and Sterilization Forms:

- Acknowledgement of Receipt of Hysterectomy Information
- Consent to Sterilization Form

Cost Containment Form:

- Refund Notification Form

Simply Healthcare Plans, Inc.
Medicaid Managed Care

Claim Payment Appeal — Submission Form

This form should be completed by providers for payment appeals only.

Member information	
Name:	DOB:
Coverage: ☐ Medicaid ☐ Medicare	Member ID:

Provider/provider representative information		
Name:	NPI:	
Street address:		
City:	State:	ZIP:
☐ I am a participating provider. ☐ I am a nonparticipating provider.* *If filing for a Medicare member and the member has potential financial liability, you must include a completed Centers for Medicare & Medicaid Services Waiver of Liability Form.		
Provider representative: ☐ Self ☐ Billing agency ☐ Law firm ☐ Other:		
Representative contact name:		
Email:	Phone:	
Street address:		
City:	State:	ZIP:

Claim information If you have multiple claims related to the **same** issue, you can use one form and attach a listing of the claims with each supporting document following behind.	
Claim number:	Billed amount:
Amount received:	Start date of service:
End date of service:	Authorization number:

Payment appeal A payment appeal is defined as a request from a healthcare provider to change a decision made by Simply Healthcare Plans, Inc. (Simply) related to claim payment for services already provided. A provider payment appeal is **not** a member appeal (or a provider appeal on behalf of a member) of a denial or limited authorization as communicated to a member in a notice of action.
☐ First-level appeal ☐ Second-level appeal

To ensure timely and accurate processing of your request, please complete the following **Payment dispute** section by checking the applicable determination provided on the Simply determination letter or *Explanation of Payment*.

Payment dispute		
☐Untimely filing	☐Claim code editing denial	☐Denied as duplicate
☐No authorization	☐Retrospective authorization issue	☐Denial related to provider data issue
☐Denied for other health insurance (OHI), but member doesn't have OHI	☐Disagree that you were paid according to your contract	☐Member retro-eligibility issue
☐Experimental/investigational procedure denial	☐Data elements on the claim on file do not match the claim originally submitted	☐ER level of payment review
☐Other:		

Mail this form, a listing of claims (if applicable) and supporting documentation to:

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

CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.

Carelon Medical Benefits Management, Inc. is a separate company providing utilization review services on behalf of the health plan.

Carelon Behavioral Health, Inc. is a separate company providing behavioral health services on behalf of the health plan.

Provider Services: 844-405-4296
https://provider.simplyhealthcareplans.com
https://provider.clearhealthalliance.com

Simply Healthcare Plans, Inc. is a Managed Care Plan with a Florida Medicaid contract. Simply Healthcare Plans, Inc. dba Clear Health Alliance is a Managed Care Plan with a Florida Medicaid contract. Simply Healthcare Plans, Inc. is a Managed Care Plan with a Florida Healthy Kids contract.

FL-SMPLYCHA-CD-PM-FHKSMMC-019253-26-S5090