



Provider Manual

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AmeriHealth Caritas[™]

Florida

AmeriHealth Caritas Florida

Provider Manual

Effective November 1, 2022





March 25, 2024

AmeriHealth Caritas Florida would like to let you know about the following changes to our provider manual:

Chapter 2: Provider Complaint Process > Steps for Submitting a Provider Complaint

The following content includes a new AHCA provided, Florida Statewide Provider and Health Plan Claim Dispute Resolution Program which replaces the previously published Claim Dispute Resolution Program content for this section. This change is effective March 11, 2024:

Chapter 2: Provider Complaint Process

Overview

AmeriHealth Caritas Florida maintains a provider complaint system that allows the provider to dispute AmeriHealth Caritas Florida's policies, procedures, or any aspect of our administrative functions, including proposed actions, claims, billing disputes, and authorizations. Complaints are reviewed and resolved by the Provider Complaints Department.

Should a provider disagree with a claim decision, the provider may participate in the provider complaint process. Some examples could include:

- Untimely filing
- Billing edits
- Benefit limitations
- Unlisted procedure codes/non-covered codes
- Fee schedule/reimbursement rates
- Provider contract questions/concerns

Steps for Submitting a Provider Complaint

1. Download the Provider Complaint Form at www.amerihealthcaritasfl.com and complete in its entirety.
2. Submit the provider complaint to the following:

Mail:

AmeriHealth Caritas Florida Provider Complaints Dept.
PO Box 7366
London, KY 40742

Fax: 1-855-358-5853

Note: If you received a denial from one of AmeriHealth Caritas subcontractors or vendors, you must follow the directions included within their notice of determination for submitting a provider complaint.

3. Please include all relevant information to support your provider complaint, including but not limited to:
 - Fee schedules
 - Copy of contract
 - Remittance advice
 - Calculation of expected reimbursement (i.e.: DRG and EAPG calculations)
 - Coordination of Benefits (COB) or research efforts to obtain documentation of other insurance
 - Other information to support the request
4. A provider has ninety (90) days from the claims payment date to submit a provider complaint. **All provider complaints past that date will be administratively upheld.**
5. AmeriHealth Caritas Florida will send an acknowledgement letter within three (3) business days to inform you that we have received your provider complaint.
6. AmeriHealth Caritas Florida will utilize relevant statutory timelines in reviewing complaints relating to coordination of benefits issues.
7. AmeriHealth Caritas Florida will send a status update after thirty (30) days of receipt if the provider complaint is not resolved, and we will provide written notice of the status every thirty (30) days until it is resolved.
8. AmeriHealth Caritas Florida will resolve all provider complaints within sixty (60) days.
9. If the decision is to overturn the original denial, AmeriHealth Caritas Florida will send either a remittance advice, a remittance advice with payment, or written notification within three (3) business days of the decision.
10. If the decision is to uphold the original denial, this decision will be communicated to the provider via written notification within three (3) business days of the decision.
11. AmeriHealth Caritas Florida does not provide a second level dispute option. If the provider is still not in agreement with the original denial, the provider may appeal the decision by utilizing the Capital Bridge Dispute Process.

Capitol Bridge – Florida’s Statewide Provider and Health Plan Claim Dispute Resolution Program

Capitol Bridge is an independent dispute resolution organization that provides assistance to healthcare providers and health plans for resolving claim disputes. Claim disputes must have been submitted by the provider to the plan and they must have been denied in full or in part or where presumed to have been underpaid or overpaid. Disputes regarding late payments will not be considered by. Please visit AHCA’s website for further information and a complete list of claims that will not be considered in the dispute resolution program:

<https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/commercial-managed-care/statewide-provider-and-health-plan-claim-dispute-resolution-program-faq>.



March 1, 2024

AmeriHealth Caritas Florida would like to let you know about the following correction to our provider manual:

Chapter 4: Population Health

The following content replaces the previously published content for this section:

Denials Based on Lack of Medical Necessity

If you receive an adverse benefit determination (denial) from AmeriHealth Caritas Florida, you have five **(5) business days** from the verbal, online or faxed notice of adverse determination to request a peer-to-peer discussion with an AmeriHealth Caritas Florida medical director. You may request a peer-to-peer discussion by contacting Utilization Management at **1-855-371-8074**. Be prepared to provide a convenient time to receive a call from the AmeriHealth Caritas Florida medical director. If you still disagree with a decision to uphold a denial after the peer-to-peer discussion, you have the right to file an appeal. If the adverse benefit determination was related to a pre-service authorization request, you can file an appeal on behalf of the member within sixty (60) days of notification of the upheld denial decision. The appeal will require the member's written consent.



July 20, 2023

AmeriHealth Caritas Florida would like to let you know about the following changes to our provider manual:

Chapter 1: Claims and Billing > Electronic Claims Submission

The following content replaces the previously published content for this section:

Electronic Claim Submission

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high-level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

AmeriHealth Caritas Florida EDI Payer ID. The AmeriHealth Caritas Florida EDI Payer ID is 77003.

Hardware/software requirements. There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to Change Healthcare through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

Contracting with Change Healthcare and other electronic vendors. If you are a provider interested in submitting claims electronically to AmeriHealth Caritas Florida, but do not currently have Change Healthcare EDI capabilities, you can contact Provider Services at **1-800-617-5727** and we will assist you. Or if you prefer, you can contract with another EDI clearinghouse or vendor who already has Change Healthcare capabilities.

Electronic claim flow description. In order to send claims electronically to AmeriHealth Caritas Florida, all EDI claims must first be forwarded to Change Healthcare. Once Change Healthcare receives the transmitted claims, the claim is validated for HIPAA compliance and AmeriHealth Caritas Florida payer edits. Claims not meeting requirements will be rejected and returned electronically via a Change Healthcare error report. The name of this report can vary based upon your contract with your EDI vendor or Change Healthcare.

All 837 claims should be compliant with SNIP level 4 standards, with exception to 2010BB Loop REF segment with G2 Qualifier (Provider legacy id). Please ensure AMT fields are limited to two decimal places.

Accepted claims are passed along to AmeriHealth Caritas Florida for processing. Change Healthcare returns an acceptance report to the sender immediately.

Claims forwarded to AmeriHealth Caritas Florida by Change Healthcare are immediately validated against provider and member eligibility records. Claims that do not meet this requirement are rejected and sent back to Change Healthcare, which also forwards this rejection to its trading partner – the EDI vendor or provider. Claims passing eligibility requirements are then forwarded to the claim processing queues. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

As a network provider, you are responsible for the verification of EDI claims receipts, as well as acknowledgements for accepted or rejected claims received from Change Healthcare, or other contracted EDI software vendors. It is your responsibility to review and validate against transmittal records daily.

Since Change Healthcare returns acceptance reports directly to the sender, submitted claims not accepted by Change Healthcare are not transmitted to AmeriHealth Caritas Florida.



For assistance in resolving submission issues, contact Change Healthcare Provider Support directly at **1-877-363-3666**.

Plan specific electronic edit requirements. AmeriHealth Caritas Florida has specific edits for professional and institutional claims sent electronically. They are as follows:

- 837P – 005010X098A1 – Provider ID Payer Edit states the ID must be less than thirteen (13) alphanumeric digits.
- 837I – 005010X096A1 – Provider ID Payer Edit states the ID must be less than thirteen (13) alphanumeric digits.
- Member number must be less than seventeen (17) alphanumeric digits. Date submitted must not be earlier than date of service. Plan Provider ID is strongly encouraged.

National Provider Identification (NPI) processing. AmeriHealth Caritas Florida provider numbers are created from individual NPI numbers using any of the following criteria:

- AmeriHealth Caritas Florida ID, Tax ID and NPI numbers;
- Service location's ZIP code;
- Billing address; or
- Taxonomy.

If no single match is found, the claim is sent to the invalid provider queue for processing. If a plan provider ID is sent using the G2 qualifier, it is used as the provider on the claim.

NPI Usage for Claims Processing. As of March 1, 2022, AmeriHealth Caritas Florida will utilize AHCA's matching criteria to ensure that the provider information submitted on the claim is matched to a unique Florida Medicaid ID on AHCA's Provider Master List (PML). Claims that are unable to be matched to an active record on the PML will result in denial. To avoid such denials, please ensure that the following data elements submitted on the claim match to an active Florida Medicaid PML record for the date of service:

- Provider NPI
- Provider taxonomy
- Provider street address
- Provider zip+4

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Welcome to AmeriHealth Caritas Florida

We are pleased to have you participating in our network. Our provider manual has been designed to provide important information on processes, programs and the delivery of care to AmeriHealth Caritas Florida members.

AmeriHealth Caritas Florida is contracted with the Agency for Health Care Administration (AHCA) as a participant in Florida's Statewide Medicaid Managed Care (SMMC) program. As a Florida-based company, AmeriHealth Caritas Florida is dedicated to serving the needs of Floridians enrolled in the SMMC program.

Florida Medicaid and the Statewide Medicaid Managed Care (SMMC) Program. Florida has offered Medicaid services since 1970. Medicaid provides healthcare coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7170, creating Part IV of Chapter 409, F.S. to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services including long term care services. The SMMC program has three components, the Long-Term Care (LTC) program, the Managed Medical Assistance (MMA) program, and the Dental Program. Our model of care provides an integrated approach to person-centered care for all aspects of a members' well-being. AmeriHealth Caritas Florida has a long history of advancing excellence in delivering quality health care to members. The key to our success is the long-standing collaborative relationships we enjoy with network practitioners and providers.

Thank you for your participation and commitment to care for our members.

Your Quick Reference Guide

Please visit our website at www.amerhealthcaritasfl.com to learn more about AmeriHealth Caritas Florida, including the following:

- Provider forms
- Provider directories (online searchable and printable)
- Claims and billing information including billing guide
- Clinical guidelines
- Online training
- Provider updates and newsletters

Create your secure online account today. Register for access to the AmeriHealth Caritas Florida secure provider portal to manage your AmeriHealth Caritas Florida transactions online at www.navinet.net. If you prefer, we can help you set up your account. Call Provider Services at **1-800-617-5727**. You can perform the following tasks online through your secure account:

- Confirm member eligibility
- Check the status of your claims
- Determine which services require a prior authorization
- Request and view your prior authorizations
- Run and review clinical reports
- Review panel and capitation rosters

We're ready to help you get started. Call us at 1-800-617-5727 to learn more about:

- Becoming a participating provider
- Checking on member eligibility or verification
- Learning about practice tools and services available to you
- Getting questions about a claim status answered

Electronic claims transactions.

- In order to send claims electronically to AmeriHealth Caritas Florida, claims must first be forwarded to Change Healthcare Solutions LLC (Change Healthcare). This can be completed via a direct submission or through another EDI clearinghouse or vendor.
- If you are a provider interested in submitting claims electronically to AmeriHealth Caritas Florida, but do not currently have Change Healthcare EDI capabilities, you can contact:
 - Change Healthcare Provider Support Line at **1-877-363-3666**
 - AmeriHealth Caritas Florida Provider Services Department at **1-800-617-5727**
 - AmeriHealth Caritas Florida Website: www.amerhealthcaritasfl.com
- AmeriHealth Caritas Florida EDI Payer ID: 77003

Electronic claims payments.

AmeriHealth Caritas Florida is now offering more choice in payment methods. Electronic claim payment has the added benefit of reducing potential exposure risk associated with paper checks.

Payment options:

- **Electronic fund transfer (EFT) payments.**

- **Virtual credit card (VCC) services.** VCC payment is your default payment method, more information is available in Chapter 1 of this manual.

Population Health Management.

Our population health management team oversees utilization management, case management and care coordination for members. Prior authorization is required for both elective and scheduled services. Please use the AmeriHealth Caritas Florida online prior authorization tool at www.amerhealthcaritasfl.com/provider/resources/prior-authorization-lookup.aspx.

To reach AmeriHealth Caritas Florida Utilization Management, please call 1-855-371-8074.

Chapter 1: Claims and Billing

Definitions

Clean claim -- a claim received in a nationally accepted format, in compliance with standard coding guidelines, that can be processed by AmeriHealth Caritas Florida without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 C.F.R. §447.45.

Non-clean claim -- a claim requiring additional information from the provider of the service, or from a third party. Non-clean claims contain errors/omissions of data or require submission of additional medical records. In addition, non-clean claims may involve issues regarding medical necessity or those not submitted within the filing deadlines.

Encounter vs. claim -- *Encounter data* is used to evaluate quality and utilization management. AmeriHealth Caritas Florida requires capitated providers to submit an encounter (also called a "proxy claim") or a claim for each service that you render to a health plan member. The information for each member visit must be submitted on a standard CMS-1500 or UB-04 form and completed with a dollar value. This is a requirement of the Centers for Medicare and Medicaid Services (CMS) and the state of Florida. A *claim* is a request for reimbursement either electronically or by paper for any medical service. Claims must be filed on the proper form, such as CMS-1500 or UB-04. A claim will be paid or denied with an explanation for the denial. For each claim processed, a remittance advice will be available electronically or will be mailed to the provider who submitted the original claim.

Procedures for Claim Submission

AmeriHealth Caritas Florida is required by state and federal regulations to capture specific data regarding services rendered to members. As such, we ask that network providers adhere to all billing requirements in order to ensure timely processing of claims.

When required data elements are missing or are invalid, claims will be rejected for correction and re-submission.

Claims for billable and capitated services provided to AmeriHealth Caritas Florida members must be submitted by the provider who performed the services. All claims are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of electronic claims against 837 edits at Change Healthcare.
- Verification of member eligibility for services under AmeriHealth Caritas Florida during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible member.
- Verification that the provider participated in the Florida Medicaid program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas Florida.
- Verification of whether there is Medicare coverage or any other third party resources and, if so, verification that AmeriHealth Caritas Florida is the "payer of last resort" on all claims to AmeriHealth Caritas Florida.
- Verification that provider data elements submitted on the claim are an exact match to the provider data stored on the Agency for Health Care Administration Provider Master List (PML).

Claim Filing Deadlines

Original invoices must be submitted to AmeriHealth Caritas Florida as set forth in your provider contract, or as otherwise permitted by law, from the date services were rendered or compensable items were provided. Re-submission of previously

denied claims with corrections and requests for adjustments must be submitted within the allowed time frame listed in your participating provider’s contract, or as otherwise permitted by law, or as outlined in federal/state statutes. Claims with explanation of benefits from primary insurers must be submitted within the following timeframes:

- For third-party liability or coordination of benefits claims, the time filing limit is 90 days from the date of the primary payer’s final determination.
- For Medicare coordination of benefit claims the time filing limit is 36 months from the date of service or 90 days from the date of the primary payer’s final determination, whichever is greater. Medicare crossover claims shall not be denied solely based on the date span between date of service and the date a clean claim was received, unless this period exceeds three years.

As a helpful tool, please refer to the claims timeframes below:

| Action | Timeframe | Timeframe begins |
|---|-----------|---|
| Initial Claim Submission (ACFL is primary payer) | 6 months* | Date of discharge (inpatient) or date of service (outpatient) |
| Corrected Claim Submission (ACFL is primary payer) | 6 months* | Date of discharge (inpatient) or date of service (outpatient) |
| Initial Claim Submission (ACFL is secondary payer) | 90 days* | Date of primary payer’s final determination |
| Corrected Claim Submission (ACFL is secondary payer) | 90 days* | Date of primary payer’s final determination |

**Provider’s contractual timeframe will prevail when more advantageous than the timeframes outlined above.*

Paper Claim Submission

Paper claims should be submitted to AmeriHealth Caritas Florida at the following address:

AmeriHealth Caritas Florida
 Attn: Claim Processing Department
 P.O. Box 7367
 London, KY 40742

We encourage all providers to submit claims electronically. Please call your EDI software vendor or the Change Healthcare Provider Support Line at **1-877-363-3666** to arrange transmission.

AmeriHealth Caritas Florida is authorized to take whatever steps are necessary to ensure that as a network provider, you are recognized by the SMMC program -- including its choice counseling/enrollment broker contractor(s) -- as a participating provider of AmeriHealth Caritas Florida, and that your submission of encounter data is accepted by the Florida Medicaid Management Information System.

Electronic Claim Submission

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high-level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

AmeriHealth Caritas Florida EDI Payer ID. The AmeriHealth Caritas Florida EDI Payer ID is 77003.

Hardware/software requirements. There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to Change Healthcare through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

Contracting with Change Healthcare and other electronic vendors. If you are a provider interested in submitting claims electronically to AmeriHealth Caritas Florida, but do not currently have Change Healthcare EDI capabilities, you can contact Provider Services at **1-800-617-5727** and we will assist you. Or if you prefer, you can contract with another EDI clearinghouse or vendor who already has Change Healthcare capabilities.

Electronic claim flow description. In order to send claims electronically to AmeriHealth Caritas Florida, all EDI claims must first be forwarded to Change Healthcare. Once Change Healthcare receives the transmitted claims, the claim is validated for HIPAA compliance and AmeriHealth Caritas Florida payer edits. Claims not meeting requirements will be rejected and returned electronically via a Change Healthcare error report. The name of this report can vary based upon your contract with your EDI vendor or Change Healthcare.

Accepted claims are passed along to AmeriHealth Caritas Florida for processing. Change Healthcare returns an acceptance report to the sender immediately.

Claims forwarded to AmeriHealth Caritas Florida by Change Healthcare are immediately validated against provider and member eligibility records. Claims that do not meet this requirement are rejected and sent back to Change Healthcare, which also forwards this rejection to its trading partner – the EDI vendor or provider. Claims passing eligibility requirements are then forwarded to the claim processing queues. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

As a network provider, you are responsible for the verification of EDI claims receipts, as well as acknowledgements for accepted or rejected claims received from Change Healthcare, or other contracted EDI software vendors. It is your responsibility to review and validate against transmittal records daily.

Since Change Healthcare returns acceptance reports directly to the sender, submitted claims not accepted by Change Healthcare are not transmitted to AmeriHealth Caritas Florida.

For assistance in resolving submission issues, contact Change Healthcare Provider Support directly at **1-877-363-3666**.

Plan specific electronic edit requirements. AmeriHealth Caritas Florida has specific edits for professional and institutional claims sent electronically. They are as follows:

- 837P – 005010X098A1 – Provider ID Payer Edit states the ID must be less than thirteen (13) alphanumeric digits.
- 837I – 005010X096A1 – Provider ID Payer Edit states the ID must be less than thirteen (13) alphanumeric digits.
- Member number must be less than seventeen (17) alphanumeric digits. Date submitted must not be earlier than date of service. Plan Provider ID is strongly encouraged.

National Provider Identification (NPI) processing. AmeriHealth Caritas Florida provider numbers are created from individual NPI numbers using any of the following criteria:

- AmeriHealth Caritas Florida ID, Tax ID and NPI numbers;
- Service location's ZIP code;
- Billing address; or
- Taxonomy.

If no single match is found, the claim is sent to the invalid provider queue for processing. If a plan provider ID is sent using the G2 qualifier, it is used as the provider on the claim.

NPI Usage for Claims Processing. As of March 1, 2022, AmeriHealth Caritas Florida will utilize AHCA's matching criteria to ensure that the provider information submitted on the claim is matched to a unique Florida Medicaid ID on AHCA's Provider Master List (PML). Claims that are unable to be matched to an active record on the PML will result in denial. To avoid such denials, please ensure that the following data elements submitted on the claim match to an active Florida Medicaid PML record for the date of service:

- Provider NPI
- Provider taxonomy
- Provider street address
- Provider zip+4

Inpatient Claim Submission

AmeriHealth Caritas Florida validates that only properly billed claims are paid. As such, all inpatient Diagnosis Related Grouper (DRG) facility claims that will pay greater than \$40,000, if paid as billed, and are billed with cost outliers of \$1,000 or more, will be subject to a prepayment review. This prepayment review service will be conducted by an external vendor to review the cost outlier portion of the inpatient claim for billing inconsistencies and variances from industry billing practices.

To help ensure timely processing of inpatient claims, AmeriHealth Caritas Florida requires that you submit an itemized bill with each inpatient DRG facility claim that will pay greater than \$40,000, if paid as billed. **Inpatient claims meeting this criteria must be submitted with an itemized bill to avoid an upfront denial.** Such claims received *without* an itemized bill will be denied with denial code *EQ8 - Reimbursement exceeds \$40,000, resubmit with itemized bill*. If you receive an upfront denial, please follow the instructions provided on the remittance advice to ensure proper and timely submission of the itemized bill.

Please note that the level of monetary criteria for review as noted above is subject to change.

Corrected, Replacement, and Voided Claim Submission

Corrected, replacement and voided claims should be sent electronically or on paper and should be submitted to AmeriHealth Caritas Florida in accordance with the following guidelines:

- If sent electronically, the **claim frequency code** (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) must contain the value **'7'** for the replacement (correction) of a prior claim or **'8'** for the void of a prior claim.
- In addition, you must also provide the original claim number in **Payer Claim Control Number** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a unique requirement of AmeriHealth Caritas Florida, but rather a requirement of the mandated *HIPAA Version 5010 Implementation Guide*.
- Each unique claim number can only be *corrected* one time. If you have already filed a corrected claim, and need to correct it a second time, please utilize the most recent claim number in the **Payer Claim Control Number**. If the corrected claim is submitted on paper, the claim must have the following in order to be processed:
 - On a professional CMS-1500 Claim, the resubmission code of "7" or "8" and the AmeriHealth Caritas Florida claim number must be in Field 22.
 - On an institutional UB-04 Claim, bill type should end in "7" or "8" in Form Locator 4 and the AmeriHealth Caritas Florida claim number must be in Form Locator 64A (Document Control Number).
- You can only resubmit as a corrected or replacement claim when you have received an AmeriHealth Caritas Florida claim number.

Please do not utilize the corrected claim process if the claim was rejected by AmeriHealth Caritas Florida.

Please submit corrected claims using the appropriate **Paper Claim Submission** or **EDI Claim Submission** guidelines above.

Claims Payments

Clean claims will be adjudicated (finalized as paid or denied) within the following timeframes:

- EDI – nursing facility and hospice clean claims – 10 business days from date of receipt.
- EDI – non-nursing facility and non-hospice clean claims – 15 days from date of receipt.
- Paper – 20 days from date of receipt.

Payment options AmeriHealth Caritas Florida is offering more choice in payment methods. Electronic claim payment has the added benefit of reducing potential exposure risk associated with paper checks.

- **Virtual credit card (VCC) services.** VCC payment is your default payment method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, your Explanation of Payment (EOP) and an instruction page for processing. Normal transaction fees apply based on your merchant acquirer relationship. To opt out of this VCC payment method, you can contact ECHO directly at 1-888-492-5579.
- **Electronic fund transfer (EFT) payments.**
 - Payments appear on your bank statement.
 - If you are using a practice management system, be sure your software reflects the new ECHO payer ID 58379 in addition to the AmeriHealth Caritas Florida payer ID 77003 to receive Electronic Remittance Advices (ERAs).
 - All generated ERAs will also be accessible to download from the ECHO provider portal (www.providerpayments.com). Changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Enrollment team at 1-888-834-3511.
- **New to EFT payments.** If you are interested in receiving payment via EFT, setting up EFT is fast and straightforward. In addition to your banking account information, you will need to provide an ECHO payment draft number and payment amount as part of the enrollment authentication.
 - To sign-up to receive EFT from AmeriHealth Caritas Florida and any affiliated plans in the AmeriHealth Caritas Family of Companies, visit <https://enrollments.echohealthinc.com/efteradirect/enroll>. You only need to enroll once for all AmeriHealth Caritas Florida affiliated plans and **there is no fee**.
 - To sign up for EFT, from **all** payers you work with to process payments on the ECHO platform, visit <https://enrollments.echohealthinc.com/>. **A fee for this service may apply.**
- **MedPay.** If you are not enrolled with us to receive payments via EFT and you opt-out of Virtual Credit Card, and have enrolled for Medical Payment Exchange (MPX) with another payer, you will continue to receive your payments in your MPX portal account. Otherwise, you will receive a paper check via print and mail.
- **Paper check.** To receive paper checks and paper EOPs, you must opt out of the Virtual Card Services by contacting ECHO Health at 1-888-492-5579, after your initial virtual card payment is received.

In addition, we want to make you aware that you will also be able to log into www.providerpayments.com to access a detailed EOP for each payment from AmeriHealth Caritas Florida.

Submitting a Refund

AmeriHealth Caritas Florida encourages providers to conduct regular self-audits to ensure receipt of accurate payment(s) from AmeriHealth Caritas Florida. Medicaid program funds must be returned when identified as improperly paid or overpaid.

If a plan provider identifies improper payment or overpayment of claims from AmeriHealth Caritas Florida, the improperly paid or overpaid funds must be returned to AmeriHealth Caritas Florida within 60 days from the date of discovery of the overpayment. Providers should return improper or overpaid funds to AmeriHealth Caritas Florida by:

1. Completing the Provider Claim Refund Form available online at www.amerihhealthcaritasfl.com.
 - a. Use page two of the form or attach your own spreadsheet with the pertinent fields from the form, as needed, to list multiple claims connected to the return payment.
2. Submitting the completed form, attachments and refund check by mail to the claims processing department:
AmeriHealth Caritas Florida
Attn: Provider Refund Unit
PO Box 7367
London, KY 40742

We aspire to provide an exceptional service experience. In order to expedite the processing of refunds, providers are encouraged to submit individual refunds (one claim per check). This will allow for automated processing and provide a faster turnaround time for the refund to be applied.

Additional Claim Submission Guidelines

Medicaid Well-Child Visits: Services are identified using the CPT Preventative Medicine Services Codes. In some cases, one or two modifiers are required to uniquely identify the service provided.

Each preventative medicine service code billed will be required to have a referral code with the exception of Family Planning services (99383-99385 with modifier FP, or 99393-99395 with modifier FP).

Family Planning services do not require a well-child referral code.

Procedure Codes

- **99381:** New Patient Under One Year
- **99382:** New Patient Ages 1-4 years
- **99383:** New Patient Ages 5-11 Years
- **99384:** New Patient Ages 12-17 Years
- **99385 EP:** New Patient Ages 18-20 Years
- **99391:** Established Patient Under One Year
- **99392:** Established Patient Ages 1-4 years
- **99393:** Established Patient Ages 5-11 Years
- **99394:** Established Patient Ages 12-17 Years
- **99395 EP:** Established Patient Ages 18-20 Years

Modifiers

- **EP:** used with procedure code 99385 and 99395 to identify children 18 through 20 years of age
- **FP:** used with procedure code 99383-99385 or 99393-99395 when the appropriate diagnosis is billed for Family Planning services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Referral Codes

Providers who submit paper claims must complete field **24H** (EPSDT Family Plan) on the CMS1500 claim form.

- **AV:** Available-not used (member refused referral)
- **NU:** Not used (no EPSDT member referral given)
- **S2:** Under treatment (member currently under treatment for referred diagnostic or corrective health problem)

- **ST:** New service requested (member referred to another provider for diagnostic or corrective treatment or scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals)

Electronic Claims

Providers who bill electronically using the 837P format must select the appropriate response for ASC X12N 837: Loop 2300 element CRC02 – "Was an EPSDT referral given to the patient? (Yes or No)" and provide the appropriate condition indicator in element CRC03 of the electronic claims file. Providers should also submit a value of "Y" in Loop 2400 segment SV111.

Please refer to the table below for assistance with billing EPSDT claims.

| EPSDT | EPSDT and Family Planning |
|---|--|
| <p>If an EPSDT referral was given:</p> <ul style="list-style-type: none"> • Loop 2300, Segment CRC02 = Y • Loop 2300, Segment CRC03 = one of the following: <ul style="list-style-type: none"> ○ AV Available-not used (member refused referral) ○ S2 Under treatment ○ ST New service requested • Loop 2400, Segment SV111 = Y <p>If the service is an EPSDT service and no follow-up services are required:</p> <ul style="list-style-type: none"> • Loop 2300, Segment CRC02 = N • Loop 2300, Segment CRC03 = NU | <p>If an EPSDT referral was given:</p> <ul style="list-style-type: none"> • Loop 2300, Segment CRC02 = Y • Loop 2300, Segment CRC03 = one of the following: <ul style="list-style-type: none"> ○ AV Available-not used (member refused referral) ○ S2 Under treatment ○ ST New service requested • Loop 2400, Segment SV111 = Y • Loop 2400, Segment SV112 = Y <p>If the service is an EPSDT service and no follow-up services are required:</p> <ul style="list-style-type: none"> • Loop 2300, Segment CRC02 = N • Loop 2300, Segment CRC03 = NU |

Common Causes of Claim Processing Delays, Rejections or Denials:

- **Authorization or Referral Number Invalid or Missing** - A valid authorization number must be included on the claim form for all services requiring prior authorization.
- **Attending Provider ID Missing or Invalid** – Inpatient claims must include the name of the provider who has primary responsibility for the member's medical care or treatment, and the medical license number on the appropriate lines in field number 82 (attending provider ID) of the UB-04 (CMS 1450) claim form. A valid medical license number is formatted as two (2) alpha, six (6) numeric, and one (1) alpha character (AANNNNNA) **OR** two (2) alpha and six (6) numeric characters (AANNNNNN).
- **Billed Charges Missing or Incomplete** – a billed charge amount must be included for each service/procedure/supply on the claim form.
- **CLIA Number Missing or Invalid** - Providers that perform laboratory testing are required to indicate their CLIA ID number when submitting claims. Ensure that the CLIA certificate is active on the date of service and that the procedure is covered under the CLIA certification type.
- **Diagnosis, Procedure or Modifier Codes Invalid or Missing** - coding from the most current coding manuals (ICD-10, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

- **Explanation of Benefits (EOB) from Primary Insurers Missing or Incomplete** – a copy of the explanation of benefit from all third-party insurers must be submitted with the original claim form. Please ensure that the EOB is complete, and includes processing/payment dates, coding explanations and messages.
- **External Cause of Injury Codes** – external cause of injury “E” diagnosis codes should not be billed as primary and/or admitting diagnosis.
- **Future Claim Dates** – claims submitted for medical supplies or services with future claim dates will be denied, for example, a claim submitted on October 1st for bandages that are delivered for October 1st through October 31st will deny for all days except October 1st.
- **Handwritten Claims** – handwritten claims are not acceptable and will be rejected.
- **Illegible Claim Information** – information on the claim form must be legible in order to avoid delays or inaccuracies in processing. Review billing processes to ensure that forms are typed or printed in black ink, data is lined up correctly in appropriate fields, that no fields are highlighted (this causes information to darken when scanned or filmed), and that spacing and alignment are appropriate. Handwritten information often causes delays or inaccuracies due to reduced clarity.
- **Member Plan Identification Number is Missing or Invalid** – AmeriHealth Caritas Florida’s assigned identification number must be included on the claim form or electronic claim submitted for payment.
- **Member Date of Birth Does Not Match Member ID Submitted** – a newborn claim submitted with the mother’s ID number will be pended for manual processing causing delay in prompt payment.
- **Newborn Claim Information Missing or Invalid** – always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert “Baby Girl” or “Baby Boy” in front of the mother’s last name as the baby’s first name. Verify that the appropriate last name is recorded for the mother and baby.
- **Payer or Other Insurer Information Missing or Incomplete** – Include the name, address and policy number for all insurers covering the AmeriHealth Caritas Florida member.
- **Primary Explanation of Benefits Required** – The member has other insurance as primary and the primary explanation of benefits was not submitted with the claim.
- **Valid Florida Medicaid ID** – Ensure that the billing and servicing providers have a valid Medicaid ID with the State of Florida and that the NPI, taxonomy, address, and zip+4 match to an active record on the Agency’s Provider Master List (PML).

Prospective claims editing policy: Our claim payment policies, and the resulting edits, are based on guidelines from established industry sources. These include the Centers for Medicare and Medicaid Services (CMS), American Medical Association, state regulatory agencies and medical specialty professional societies.

In making claim payment determinations, AmeriHealth Caritas Florida uses coding terminology and methodologies that are based on accepted industry standards. These include the Healthcare Common Procedure Coding System manual, the Current Procedural Terminology codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code.

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policies. These factors may include but are not limited to: legislative or regulatory mandates, a provider’s contract, and/or a member’s eligibility to receive covered healthcare services.

AmeriHealth Caritas Florida has a claim editing subcontractor. You may see Explanation of Benefits (EOB) explanation codes on zero paid lines. Coding and billing edits are applied **before** pricing. You may reference the list of current EOB codes by visiting <https://www.amerhealthcaritasfl.com/provider/claims-and-billing/index.aspx>.

Billing forms: Please submit claims using standardized claim forms whether filing on paper or electronically. Refer to the appropriate provider handbook, issued by AHCA at <http://ahca.myflorida.com/medicaid/review/index.shtml>, to determine which claim form is appropriate for each type of service.

Third party liability: Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the healthcare expenses of the member. Please verify member eligibility prior to serving the member and verify third party sources prior to billing AmeriHealth Caritas Florida.

CMS crossover claims: In accordance with guidance from CMS, providers only need to submit claims for dual eligible members once to CMS for processing and are no longer required to submit secondary claims to AmeriHealth Caritas Florida. This means that CMS will automatically forward claims to AmeriHealth Caritas Florida for members who are dually eligible for both Medicare and Medicaid coverage.

Please note: If a provider submits a claim for a dually eligible member that CMS has already forwarded to AmeriHealth Caritas Florida, we will deny the provider-submitted claim as a duplicate claim.

Billing the member. Providers may *not* bill a member for Medicaid-covered services for which a claim has been submitted, regardless of whether the claim has been paid or denied.

Program Integrity

AmeriHealth Caritas Florida is obligated to ensure the effective use and management of public resources in the delivery of services to its members. AmeriHealth Caritas Florida does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of AmeriHealth Caritas Florida, regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

- **Prospective (Pre-claims payment)**
 - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services (“CMS”), the American Medical Association (“AMA”), state regulatory agencies or AmeriHealth Caritas Florida medical/claim payment policy) are applied to prepaid claims.
 - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
 - *Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.*
 - Coordination of Benefits (“COB”) - Process to verify third party liability to ensure that AmeriHealth Caritas Florida is only paying claims for members where AmeriHealth Caritas Florida is responsible, i.e. where there is no other health insurance coverage.
 - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

- **Retrospective (Post-claims payment)**
 - Third Party Liability (“TPL”)/Coordination of Benefits (“COB”)/Subrogation – As a Medicaid plan, AmeriHealth Caritas Florida is the payer of last resort. The effect of this rule is if AmeriHealth Caritas Florida determines a member has other health insurance coverage, payments made by AmeriHealth Caritas Florida may be recovered.
 - Please also see Chapter 1: Claims and Billing for further description of TPL/COB/Subrogation.
 - Data Mining – Using paid claims data, AmeriHealth Caritas Florida identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
 - Medical Records Review/Itemized Bill review – a Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation of procedures, diagnosis or diagnosis-related group (“DRG”) billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
 - *Please note if medical records are not received within the requested timeframe, AmeriHealth Caritas Florida will recoup funds from the provider. Your failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.*
- **Credit Balance Issues**
 - Credit balance review service conducted in-house at the provider’s facility to assist with the identification and resolution of credit balances at the request of the provider.
 - Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you need to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas Florida reserves the right to adjust any payment made following a review of the medical records or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member’s eligibility changes between when the authorization was issued and the service was provided.

Chapter 2: Provider Complaint Process

Overview

AmeriHealth Caritas Florida maintains a provider complaint system that allows the provider to dispute AmeriHealth Caritas Florida's policies, procedures, or any aspect of our administrative functions, including proposed actions, claims, billing disputes, and authorizations. Complaints are reviewed and resolved by the Provider Complaints Department.

Should a provider disagree with a claim decision, the provider may participate in the provider complaint process. Some examples could include:

- Untimely filing
- Billing edits
- Benefit limitations
- Unlisted procedure codes/non-covered codes
- Fee schedule/reimbursement rates
- Provider contract questions/concerns

Steps for Submitting a Provider Complaint

1. Download the Provider Complaint Form at www.amerhealthcaritasfl.com and complete in its entirety.
2. Submit the provider complaint to the following:
 - Mail: AmeriHealth Caritas Florida Provider Complaints Dept.
PO Box 7366
London, KY 40742
 - Fax: 1-855-358-5853

Note: If you received a denial from one of AmeriHealth Caritas subcontractors or vendors, you must follow the directions included within their notice of determination for submitting a provider complaint.
3. Please include all relevant information to support your provider complaint, including but not limited to:
 - Fee schedules
 - Copy of contract
 - Remittance advice
 - Calculation of expected reimbursement (i.e.: DRG and EAPG calculations)
 - Coordination of Benefits (COB) or research efforts to obtain documentation of other insurance
 - Other information to support the request
4. A provider has ninety (90) days from the claims payment date to submit a provider complaint. **All provider complaints past that date will be administratively upheld.**
5. AmeriHealth Caritas Florida will send an acknowledgement letter within three (3) business days to inform you that we have received your provider complaint.
6. AmeriHealth Caritas Florida will utilize relevant statutory timelines in reviewing complaints relating to coordination of benefits issues.
7. AmeriHealth Caritas Florida will send a status update after thirty (30) days of receipt if the provider complaint is not resolved and we will provide written notice of the status every thirty (30) days until it is resolved.
8. AmeriHealth Caritas Florida will resolve all provider complaints within sixty (60) days.
9. If the decision is to overturn the original denial, AmeriHealth Caritas Florida will send either a remittance advice, a remittance advice with payment, or written notification within three (3) business days of the decision.
10. If the decision is to uphold the original denial, this decision will be communicated to the provider via written notification within three (3) business days of the decision.

11. AmeriHealth Caritas Florida does not provide a second level dispute option. If the provider is still not in agreement with the original denial, the provider may appeal the decision by utilizing the MAXIMUS Dispute Process.

MAXIMUS – Florida Statewide Provider and Health Plan Claim Dispute Resolution Program

MAXIMUS is an independent dispute resolution organization that provides assistance to healthcare providers and health plans for resolving claim disputes. Claim disputes must have been submitted by the provider to the plan and they must have been denied in full or in part or where presumed to have been underpaid or overpaid. Disputes regarding late payments will not be considered by MAXIMUS.

Chapter 3: Member Complaints, Grievances, and Appeals

Member Complaints

Complaints allow AmeriHealth Caritas Florida to resolve a problem without it becoming a formal grievance. If a member has a concern or question regarding care or coverage under AmeriHealth Caritas Florida, he/she should contact Member Services at the toll-free number on the back of his/her ID card. A Member Services Representative will answer questions and/or concerns. The Member Services Representative will try to resolve the problem. If the Member Services Representative does not resolve the problem to the member's satisfaction, he/she has the right to file a grievance. A complaint that is not resolved by close of business the day following its receipt is automatically moved into the AmeriHealth Caritas Florida grievance system.

Grievance Process

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or AmeriHealth Caritas Florida employee, failure to respect a member's rights, or a member dispute of an extension of time proposed by the health plan to make an authorization decision. The member can file a grievance at any time by calling Member Services at **1-855-355-9800** (TTY 1-855-358-5856) twenty-four hours a day, seven days a week.

Or write to:

AmeriHealth Caritas Florida
P.O. Box 7368
London, KY 40742

If the member needs assistance in completing forms and following the procedure for filing his/her grievance or needs the help of an interpreter, the member can call Member Services at **1-855-355-9800** (TTY 1-855-358-5856). The interpreter services are free of charge to the member.

AmeriHealth Caritas Florida will send the member an acknowledgement letter within five (5) business days of receiving the grievance. AmeriHealth Caritas Florida will send a decision letter within ninety (90) days of receiving the request. In some cases, AmeriHealth Caritas Florida or the member may need more information. If the member needs more time to get information, he/she may request up to fourteen (14) additional days. If AmeriHealth Caritas Florida needs more time, the member will be informed of the reason for the extension, in writing, within two (2) calendar days.

Standard Appeal

A standard appeal can be submitted by a provider on behalf of the member. The provider, with member's consent, can call Member Services at **1-855-355-9800** (TTY 1-855-358-5856) or fax appeal request to 1-855-358-5847.

Providers can file an appeal orally or in writing on behalf of the member within 60 calendar days of the member's receipt of the Notice of Adverse Benefit Determination and, except when expedited resolution is required, must be followed with a written consent within ten calendar days of the oral filing.

Expedited Appeal

A member or his/her authorized representative, with the member's written consent, can request an expedited appeal if taking the time for a standard resolution could jeopardize the member's life, health or ability to attain, maintain or regain function. Expedited appeals are for healthcare services, not denied claims. To ask for an expedited appeal, the member or his/her authorized representative can call Member Grievances and Appeals at **1-855-371-8078**.

If AmeriHealth Caritas Florida denies a request for an expedited resolution of an appeal, AmeriHealth Caritas Florida shall provide oral notice by close of business on the day of disposition, and written notice within two (2) calendar days after the disposition. The appeal will immediately be moved into the standard appeal timeframe, if it does not meet the criteria for an expedited appeal.

AmeriHealth Caritas Florida shall resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires, within state established time frames, not to exceed forty-eight (48) hours after the request for expedited appeal is received. AmeriHealth Caritas Florida also shall provide oral notice by close of business on the day of disposition, and written notice within two (2) calendar days of the disposition.

Medicaid Fair Hearing

A provider may seek a Medicaid Fair Hearing on behalf of the member, if signed express consent has been provided by member granting permission to do so, and only after exhausting the plan's internal appeal process within one hundred twenty (120) days of the Notice of Adverse Benefit Determination (NABD). The provider addresses requests for a Medicaid Fair Hearing to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O Box 60127
Ft. Myers, FL 33906
(Toll-free) Phone: 1-877-254-1055 Fax: 1-239-338-2642 or Email: **MedicaidHearingUnit@ahca.myflorida.com**.

For more information on appeal hearings, please visit <https://www.myflfamilies.com/about-us/office-inspector-general/appeal-hearings/>.

Continuation of Benefits

The member may continue to receive services while waiting for AmeriHealth Caritas Florida's decision. The member may have to pay for the continued services if the final decision from the Medicaid Fair Hearing is against them.

If the Medicaid Fair Hearing Officer agrees with the member, AmeriHealth Caritas Florida will pay for the services received while waiting for the decision.

If the Medicaid Fair Hearing decision agrees with the member and he/she did not continue to get the services while waiting for the decision, AmeriHealth Caritas Florida will issue an authorization for the services to restart as soon as possible and AmeriHealth Caritas Florida will pay for the services.

OR

The member can continue to receive services while waiting for AmeriHealth Caritas Florida's decision if all of the following apply:

- The appeal is filed within ten (10) days after the notice of the adverse action is mailed.

- The appeal is filed within ten (10) days after the intended effective date of the action.
- The appeal is related to reduction, suspension or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization has not ended.
- The member requested the services to continue.

The member's services may continue until one (1) of the following happens:

- The member decides not to continue the appeal.
- Ten (10) days have passed from the date of the notice of resolution unless the member has requested a Medicaid Fair Hearing with continuation of services within those ten (10) days.
- The time covered by the authorization has ended or the limitations on the services are met.
- The Medicaid Fair Hearing office issues a hearing decision adverse to the member.

Chapter 4: Population Health

Utilization Management (UM)

UM activities are designed to assist our providers with the organization and delivery of appropriate healthcare services to members within the structure of the member benefit plan.

Under their participating provider agreements with AmeriHealth Caritas Florida, providers are required to comply fully with medical management programs administered by AmeriHealth Caritas Florida and its agents, including:

- Obtaining authorizations and/or providing notifications, depending upon the requested service.
- Providing clinical information to support medical necessity when requested.
- Permitting access to the member's medical information.
- Including AmeriHealth Caritas Florida's population health nurse in discharge planning discussions and meetings.
- Providing a plan of treatment, progress notes and other clinical documentation as required.

Providers can reach AmeriHealth Caritas Florida - Utilization Management - by calling **1-855-371-8074** Monday through Friday from 8:00a.m. to 5:00 p.m. After hours staff are available to assist with urgent or discharge needs at the same number after 5:00p.m., on holidays, or weekends.

Members needing assistance with UM issues can call Member Services at **1-855-355-9800** (TTY 1-855-358-5856). Interpretation services are also available through Member Services, as needed.

Providers can submit an authorization request in many ways:

- Online via our secure provider portal at www.navinet.net
- By fax
 - For outpatient or planned inpatient services, please complete the prior authorization request form and fax to **1-855-236-9285**.
 - For inpatient, Skilled Nursing Facility and Rehabilitation requests, clinical documentation and admission notifications, fax to **1-855-236-9293**.
- Call the AmeriHealth Caritas Florida Utilization Management Department at **1-855-371-8074**.
- Durable medical equipment/home health requests – **contact Coastal Care Services at 1-855-481-0505**.
- For Behavioral Health call **1-855-371-8074**.
- For transplant requests call **1-855-371-8074**.

Medical Necessity Standards

Medically necessary or medical necessity is defined as meeting the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.
- Be 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.
- Be consistent with the generally accepted professional medical standards as determined by the SMMC program, and not be experimental or investigational.
- Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide.
- Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider.

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, or a covered service/benefit.

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

AmeriHealth Caritas Florida uses InterQual and the American Society of Addiction Medicine (ASAM) Patient Placement Criteria as screening tools for UM determinations related to medical necessity.

When applying UM medical necessity criteria, UM staff also considers the individual member factors and the characteristics of the local health delivery system, including but not limited to:

- Member considerations.
 - Age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment.
- Local delivery system.
 - Availability of sub-acute care facilities or home care for post-discharge support.
 - Ability of local hospitals to provide all recommended services within the estimated length of stay.

Any decision to deny or reduce in amount, duration or scope a request for covered services will be made by clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice. In no instance will AmeriHealth Caritas Florida impose limitation or exclusions more stringent than outlined within the AHCA Contract.

Providers can request a copy of the UM criteria used in any determination by contacting AmeriHealth Caritas Florida Utilization Management at **1-855-371-8074**.

AmeriHealth Caritas Florida does not reward healthcare providers for denying, limiting, or delaying benefits or healthcare services, give incentives to staff or providers for making decisions about medically necessary services, or give rewards to provide less healthcare coverage and services.

AmeriHealth Caritas Florida has processes in place for the authorization of any medically necessary service to members under the age of twenty-one (21), in accordance with Section 1905(a) of the Social Security Act, when:

- The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule, or is not a covered service of the plan; or
- The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Prior Authorizations

Prior authorization is the process of obtaining approval in advance of a planned inpatient admission or outpatient service. AmeriHealth Caritas Florida will make an authorization decision based on the clinical information provided in the request.

Prior authorization allows for efficient use of coordinated services and ensures that members receive the most appropriate level of care, within the most appropriate place of service. Prior authorization may be obtained by the member's primary care physician, treating provider, or facility.

Reasons for requiring prior authorization may include:

- Review for medical necessity;
- Ensure services are coordinated with appropriate provider;
- Appropriateness of place of service; and/or
- Case and disease management considerations.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas Florida reserves the right to adjust any payment made following a review of the medical **record or other documentation and/or determination of the medical necessity of the services provided**. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued and the service was provided.

Prior authorizations are processed by AmeriHealth Caritas Florida Utilization Management. The most up-to-date listing of services requiring prior authorization or notification is maintained on the AmeriHealth Caritas Florida website at www.amerhealthcaritasfl.com. You can also request a listing by contacting Provider Services at **1-800-617-5727**. Providers can request prior authorization by:

- Submitting the request online via our secure provider portal at www.navinet.net. (*preferred method*)
- Completing an authorization request form and securely sending a fax request to **1-855-236-9285**. All forms are located on the AmeriHealth Caritas Florida website, www.amerhealthcaritasfl.com. (*Incomplete forms will not be processed and will be returned to the requesting provider.*)
- Calling Utilization Management at **1-855-371-8074**.

If prior authorization is not granted, associated claims will not be paid.

When requesting prior authorization:

- The prior authorization request should include the member's information, diagnosis to be treated and all CPT and/or HCPCS code(s) needed for the anticipated procedure or service.
- If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not typically required.
- If an adjustment is needed following delivery of the service, please contact Utilization Management on the next business day at **1-855-371-8074**.
- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.

Emergency room admission and related services do not require prior authorization.

Coastal Care Services manages all of AmeriHealth Caritas Florida's durable medical equipment (DME), home health and home infusion services provided in the home (billed with place of service 12) with the exception of those listed below.

When rendered in place of service 12 (home), these specific **excluded** services should be authorized by and billed to AmeriHealth Caritas Florida:

- Communication boards.
- All contraceptive medications and supplies.
- Cranial helmets.
- All end-stage renal disease services rendered in the home.
- Implantable device supplies (examples include supplies related to cochlear implants, permanent birth control, and urogynecologic surgical mesh implants).
- Inhalation solution (solution/drug should be obtained through member's pharmacy benefit).
- OB/GYN home health services:
- Please contact Optum OB Home Care Services directly by phone at **1-800-950-3963** or via fax at **1-866-252-4293** or **1-866-731-8011** prior to providing these services.
- Orthotics/prosthetics.
- Vision, hearing, and speech pathology services (HCPCS codes in the "V" series).

To request prior authorization from Coastal Care Services, please call **1-855-481-0505** or fax to 1-855-481-0606.

Standard Authorization Decisions

AmeriHealth Caritas Florida will:

- Provide notice as expeditiously as the member's health condition requires.
- Provide notice within no more than seven (7) calendar days following receipt of the request for service.

The time frame can be extended up to four (4) additional calendar days if:

- The provider or the member requests an extension; or
- AmeriHealth Caritas Florida justifies the need for additional information and how the extension is in the member's interest.

Expedited Authorization Decisions

AmeriHealth Caritas Florida will expedite authorization decisions when a provider indicates, or AmeriHealth Caritas Florida determines, that following the standard timeline could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function. Expedited requests must include a physician's order which indicates waiting for a decision under the standard time frame could endanger the member. Requests that do not meet the expedited request criteria or incomplete requests will be processed as standard authorization and processed in timeframes outlined above.

- An expedited decision must be made no later than two (2) calendar days after receipt of the request for service.
- AmeriHealth Caritas Florida may extend this time by an additional one (1) calendar day for expedited requests, if the member requests an extension or if AmeriHealth Caritas Florida justifies the need for additional information and how the extension is in the member's interest.

Prior Authorization Specific to Pregnancy-Related Services

All obstetric care requires a pregnancy notification form in order for proper and expedient payment to be made to obstetric providers. Once approved, this authorization includes three (3) obstetric ultrasounds, all regularly scheduled pre-natal visits, and four (4) post-delivery follow up appointments. In addition, for high-risk pregnancies, unlimited ultrasounds are allowed if provided by network maternal/fetal medicine specialists.

For the member, this authorization initiates AmeriHealth Caritas Florida care management follow-up from a team who works closely with pregnant members.

The pregnancy notification form is located at www.amerihealthcaritasfl.com and can be faxed to the AmeriHealth Caritas Florida Bright Start® Department at **1-855-358-5852** or submitted online via the secure provider portal at www.navinet.net.

Providers can also review the status of an existing authorization request by utilizing our secure portal www.navinet.net.

Providers must immediately notify AmeriHealth Caritas Florida of a member's pregnancy. A prenatal notification form should be completed by the OB/GYN or primary care provider during the first visit and faxed to AmeriHealth Caritas Florida as soon as possible after the initial visit. Notification of obstetric services enables AmeriHealth Caritas Florida to identify members for inclusion into the Healthy Behaviors Prenatal Program and for reporting pregnancies to the Florida Department of Children and Families.

Inpatient Concurrent Review and Discharge Planning

Inpatient facilities must notify the Utilization Management Department within one (1) business day after the date of admission.

Concurrent review determinations will be made within three (3) business days of receipt of a request for authorization with clinical information.

If medical necessity is established, an authorization will be issued to the facility for the days where medical necessity is met. In order to expedite our review, clinical information must be received with the request for authorization. Please note that a finding of lack of medical necessity for the inpatient stay or any part thereof will result in claims denials for both the facility and admitting provider.

Discharge planning activities are expected to be initiated upon admission. AmeriHealth Caritas Florida's Utilization Management Department will coordinate discharge planning efforts with the hospital's discharge planners to ensure the member receives appropriate post-discharge care. Coastal Care Services will assist in arranging post-discharge needs related to home care, home infusion and most durable medical equipment; these services may require prior authorization.

Denials Based on Lack of Medical Necessity

If you receive an adverse benefit determination (denial) from AmeriHealth Caritas Florida, you have three (3) business days from the verbal, online or faxed notice of adverse determination to request a peer-to-peer discussion with an AmeriHealth Caritas Florida medical director. You may request a peer-to-peer discussion by contacting Utilization Management at **1-855-371-8074**. Be prepared to provide a convenient time to receive a call from the AmeriHealth Caritas Florida medical director.

If you still disagree with a decision to uphold a denial after the peer-to-peer discussion, you have the right to file an appeal. If the adverse benefit determination was related to a pre-service authorization request, you can file an appeal on behalf of the member within sixty (60) days of notification of the upheld denial decision. The appeal will require the member's written consent.

Second Medical Opinion

A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the healthcare team, a member, parent(s) and/or guardian(s) or a social worker exercising a custodial responsibility. The second opinion must be provided at no cost to the member by a qualified healthcare professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

In accordance with Florida Statute 641.51, the member may elect to have a second opinion provided by a non-contracted provider located in the same geographical service area of AmeriHealth Caritas Florida. AmeriHealth Caritas Florida may require that any tests deemed necessary by a non-contracted provider be conducted by a participating AmeriHealth Caritas Florida provider.

AmeriHealth Caritas Florida providers' professional judgment concerning the treatment of a subscriber derived after review of a second opinion shall be controlling as to the treatment obligations of the health maintenance organization.

Population Health Management

AmeriHealth Caritas Florida Population Health Management (PHM) strategy uses a population health framework to strive to match Medicaid members to the level of support they need to address their medical, behavioral health and social needs. The PHM strategy utilizes a person-centered approach that listens to and respects member and family choices, including cultural, spiritual, and linguistic preferences. It provides customized, integrated, person-centered care comprehensively addressing member wellness. The strategy delivers and coordinates services in a way that blends advanced data-driven stratification and analyses with appropriate levels of individual engagement such as advocacy, communication, problem-solving, collaboration, and empowerment. These services focus on proactive medical care coordination, support and assistance to members with medical, behavioral and social issues that affect their quality of life and their health outcomes.

The PHM approach includes nurses, behavioral health clinicians, non-clinical care connectors and community health navigators, clinical pharmacists, AmeriHealth Caritas Florida medical and behavioral health directors, primary care physicians (PCPs), specialists, and community agencies. This multi-disciplinary approach works with members, caregivers, and parents/guardians to meet our members' needs at all levels in a proactive manner; a process designed to maximize health outcomes and quality of life.

The overall objective of the PHM strategy is to proactively identify and intervene with AmeriHealth Caritas Florida members with potential avoidable health care needs and to empower at-risk members to regain optimum health or improved functional capability.

The PHM strategy consists of core components that are focused on the member's level of need, including: Complex Care Management (CCM), Care Coordination, Bright Start Maternity Management, Pediatric/Adolescent Preventive Health Care, Disease Management, and Health and Wellness activities. Each component is designed around a holistic approach that addresses physical health, behavioral health and social determinants of health.

1) Keeping Members Healthy (Low Risk): Members in subsets assigned to this domain are mostly healthy. They need reminders for preventive health services and education for health promotion-related activities, including well-child visits and other preventive health services, along with access to health services to address needs as they arise.

2) Managing Emerging Risk (Moderate Risk): Members in subsets assigned to this domain have short term- needs related to a chronic condition, social determinant of health or challenges navigating the health care delivery system. These members benefit from care coordination including education on their condition, reminders for health monitoring and medication refills, connections to community resources and assistance coordinating treatment and follow-up care.

3) Managing Multiple Chronic Illnesses and/or Disabilities (High Risk): Members in subsets assigned to this domain have multiple co-morbid conditions, unstable support systems, social instability and/or need ongoing assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). They often require ongoing care management support and education to strengthen their self-management skills and achieve their individual goals. These members also need assistance to navigate and connect with needed health care services and available community supports.

4) Member Safety (All Risk): Interventions to promote member safety are implemented across the populations in the above domains. Member safety activities include management of care transitions and medication safety.

Bright Start® Program for Pregnant Members

AmeriHealth Caritas Florida has developed a comprehensive prenatal risk reduction program in an effort to decrease poor obstetrical outcomes of our pregnant population, which were evidenced by the following:

- High percentage of low birth-weight infants.

- High neonatal intensive care unit length of stay.
- Infant readmission rates.
- Rising preterm births.
- Increased incidents of maternal complication requiring extended hospitalizations.

The goals of the Bright Start Program are:

- Early identification of pregnant members.
- Early and continued intervention throughout pregnancy.
- Education and follow-up to promote recommended infant care.
- Introduction and education on inter-pregnancy care.

AmeriHealth Caritas Florida utilizes several means to identify members as early in their pregnancy as possible. These include but are not limited to SMMC state files, claims data, information from the initial health assessment, referrals from internal departments, the use of member newsletters, referral networks, and physician referrals.

Members who agree to participate in the Bright Start Program are paired with an AmeriHealth Caritas Florida Bright Start Care Manager who works closely with the member, ensuring that she has the means necessary to receive prenatal care and instruction and respond to various social and medical needs. Bright Start Care Managers offer the following types of special services to our Bright Start members:

- Motivational interviewing.
- Health coaching.
- Counseling.
- Health education.
- Connection to social support services.

Bright Start Care Managers separate pregnant members into low and high intensity risk categories:

- Low-risk pregnancy management - members receive care coordination from care connectors and receive pregnancy-related educational materials and outreach phone calls to encourage good prenatal care.
- High-risk pregnancy management - pregnant members identified at risk for preterm labor and/or other pregnancy complications are assigned a nurse care manager to provide ongoing supervision and education concerning pregnancy. A letter is sent to the member's physician to notify him/her of the member's enrollment in the program with a summary of the initial assessment.
- In-home services are available and include an obstetrical registered nurse to perform in-home assessments, pre-term labor education and progesterone injections on a weekly basis. Prior authorization is required for Makena and/or progesterone administration.

Doula referral services All pregnant members have access to a 24-hour toll free registered nurse call line at **1-855-398-5615**. All pregnant members are encouraged to select a pediatrician prior to delivery. For more information or to refer members to the Bright Start Program call **1-855-371-8076**.

Rapid Response and Outreach Team

An important component of the Population Health Management model is the Rapid Response & Outreach Team (RROT). This team was developed to address the urgent needs of our members and to support our providers and their staff. The RROT consists of registered nurses and non-clinical care connectors.

There are three key service functions performed in through the RROT:

- Inbound call service – members and providers can request support by calling the RROT at **1-855-371-8072** Monday through Friday from 8:00 a.m. to 5:00 p.m. Providers can call the RROT for assistance in coordinating office-based care for members; to request assistance for members who need community resources or to refer a member to any care management service.
- Outreach services – outreach activities include telephonic outreach such as completion of health risk assessments and support of special projects and quality initiatives. These include those related to Healthcare Effectiveness Data and Information Set (HEDIS) and EPSDT/well-child campaigns. RROT employees also initiate continuity of care calls to chronically ill members during hospital stays, to those recently discharged from the hospital and to members who have used the nurse call line within the past 24 hours.
- Care management support – care connectors support care managers by completing tasks and reminder calls in support of the individualized plan of care. These include appointment scheduling and reminders, transportation and interpreter support, member educational mailings, and other administrative tasks assigned by care managers.

Several services overlap all five core components. Each component includes targeted interventions for special needs populations, EPSDT-eligible populations and members with chronic conditions.

Let Us Know is a partnership between AmeriHealth Caritas Florida and the provider community, to collaborate in the engagement and management of our chronically ill members. We have support teams and tools available to assist in the identification, outreach, and education of these members, as well as clinical resources for providers in their care management.

There are three ways to let us know about chronically ill members:

1. **Contact our Rapid Response and Outreach Team (RROT):** the Rapid Response and Outreach Team addresses the urgent needs of our members and supports providers and their staff. This team works to assist members in overcoming barriers to healthcare goals and ensuring continuity of care. They are here to support you. Call them at **1-855-371-8072** from 8:00 a.m. to 5:00 p.m. Monday-Friday. After hours and on weekends and holidays, please call our 24-hour nurse call line at **1-855-398-5615**.
2. **Fax** a member intervention request form to **1-855-236-9281**. This form can be found at www.amerihhealthcaritasfl.com.
3. **Refer a patient to the Complex Case Management Program:** Complex Case Management is a voluntary program that focuses on prevention, education, lifestyle choices and adherence to treatment plans. It is designed to support your plan of care for members with chronic diseases such as asthma, diabetes, and coronary artery disease. Members receive educational materials and, if identified as high-risk, will be assigned to a care manager for one-on-one education and follow up. For more information, or to refer a member to the Complex Case Management Program, call **1-855-371-8072**.

Chapter 5: Benefits

Routine Services

AmeriHealth Caritas Florida provides coverage for the following routine services:

- Primary care visits – AmeriHealth Caritas Florida provides coverage for unlimited primary care visits.
- Well-child visits – please refer to the Medicaid Well-child visits section below for additional information.
- Cancer screenings.
 - Breast cancer
 - Cervical cancer
 - Colon cancer

- Family planning services and supplies.
- Fluoride varnish – AmeriHealth Caritas Florida provides coverage for the application of fluoride varnish by a physician for members up to 4 years of age.
- Immunizations – please refer to the immunization section below for additional information.

Immunizations

Preventive care includes a broad range of services (including screening tests, counseling, and immunizations/vaccines).

- Providers are required to administer immunizations in accordance with the recommended childhood immunization schedule for children and adolescents aged 18 years or younger, or when medically necessary for the member's health.
- All vaccines for which a member is eligible at the time of each visit should be administered simultaneously.
- Providers are required to participate in the Vaccines for Children Program (VFC).
- Providers are encouraged to provide the Department of Children and Families with complete immunization records as part of the Temporary Cash Assistance application process if asked by an AmeriHealth Caritas Florida member.

AmeriHealth Caritas Florida has adopted the following recommended immunization schedules for members under the age of twenty-one (21).

Immunization Schedules (childhood, adolescent and adult)

For the recommended vaccines and immunization schedules, please visit www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html for children and adolescents and www.cdc.gov/vaccines/schedules/hcp/adult.html for adults.

Visit <https://www.uspreventiveservicestaskforce.org/uspstf/> for the Guide to Clinical Preventive Services for recommendations made by the U.S. Preventive Services Task Force for clinical preventive services.

Vaccines for Children Program (VFC)

The Vaccines for Children 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. The Centers for Disease Control and Prevention purchases vaccines at a discount and distributes them to grantees, e.g., state health departments and certain local and territorial public health agencies, that then distributes them at no charge to those private providers' offices and public health clinics registered as VFC providers. Children who are eligible for VFC vaccines are entitled to receive pediatric vaccines that are recommended by the Advisory Committee on Immunization Practices. For more information visit www.cdc.gov/vaccines/programs/vfc/index.html.

- Florida Medicaid requires vaccines for Medicaid children from birth through eighteen (18) years of age. Providers for Medicaid members must use his/her VFC supply and bill AmeriHealth Caritas Florida for the administrative fee only.
- MediKids are not covered under the VFC program.
- Members nineteen (19) through twenty (20) years of age should receive their vaccinations from their primary care physician. AmeriHealth Caritas Florida will provide reimbursement for these members to the participating provider for immunizations covered by Medicaid but not provided through VFC.
- Providers are expected to plan for a sufficient supply of vaccines.
- AmeriHealth Caritas Florida will pay the immunization administration fee for continuation of care services at no less than the Medicaid rate from non-participating providers as follows:
 - The non-participating provider contacts AmeriHealth Caritas Florida at the time of service delivery; and

- The non-participating provider submits a claim for the administration of immunization services and provides medical records documenting the immunization to AmeriHealth Caritas Florida.

Medicaid Well-Child Visits

- Well-child visits include preventive and comprehensive services for eligible children birth through twenty (20) years of age and enrolled in the Medicaid program. AmeriHealth Caritas Florida's well-child visit coverage directs participating providers to adhere to the following: Conduct a comprehensive health screening evaluation that includes a past medical history, developmental history and behavioral assessment. The screening evaluation should also include:
 - A nutritional assessment
 - Comprehensive unclothed physical exam
 - Developmental assessment
 - Growth measurements
 - Appropriate immunizations based on the recommended childhood immunization schedule for the United States
 - Laboratory testing (including blood lead testing as outlined below)
 - Health education (including anticipatory guidance)
 - Dental screening (including a direct referral to a dentist for members beginning at age three (3) or earlier as indicated)
 - Vision screening (including objective testing as required)
 - Hearing screening (including objective testing as required)
 - Diagnosis and treatment
 - Referral and follow-up as appropriate
 - Blood lead testing:
 - All providers are required to screen all enrolled children for lead poisoning at the age of twelve (12) months and twenty-four (24) months.
 - Children between the ages of twelve (12) months and seventy-two (72) months must receive a screening blood lead test if there is no record of a previous test.
 - AmeriHealth Caritas Florida will provide additional diagnostic and treatment services determined to be medically necessary to a child/adolescent diagnosed with an elevated blood lead level.
 - If children or adolescents are identified as having abnormal levels of lead through blood lead screenings, AmeriHealth Caritas Florida will provide case management follow-up services.
- Providers are required to inform members when tests or screenings are due based on the periodicity schedule provided on the AHCA website at: <https://ahca.myflorida.com/medicaid/childhealthservices/chc-up/index.shtml>.
- AmeriHealth Caritas Florida does not require authorization for a member to be seen by a participating specialist when determined that it is needed by a primary care physician.
- Primary care physicians are to refer to the appropriate provider within four (4) weeks of these examinations for further assessment and treatment of conditions found during the initial examination.
- Providers are expected to cooperate with AmeriHealth Caritas Florida to accommodate new member appointments within 30 days of the member's enrollment with AmeriHealth Caritas Florida.
- Provide assistance with scheduling for members to ensure they keep medical appointments.

- Provide or coordinate other important health care diagnostic services and treatment including necessary referrals as they relate to physical and mental illnesses and/or conditions discovered through screening services in accordance with EPSDT contractual requirements.

Well-Child Visit Schedule for Exams:

- Birth or neonatal examination;
- 3-5 days for newborns discharged in less than 48 hours after delivery;
- By 1 month, and at 2, 4, 6, 9, 12, 15, 18 months, 24 months and 30 months; and
- Once per year for 3-year-olds through 20-year-olds.

A full well-child visit schedule is available at <http://ahca.myflorida.com/medicaid/childhealthservices/chc-up/index.shtml>.

Urgent and Emergency Services

AmeriHealth Caritas Florida is available for emergency services and care inquiries twenty-four hours a day, seven days a week (24/7) for members and caregivers. You can contact our 24-Hour Nurse Call Line at **1-855-398-5615**.

AmeriHealth Caritas Florida does not deny claims for emergency services and care received at a hospital due to lack of parental consent. In addition, AmeriHealth Caritas Florida does not deny payment for treatment obtained when a representative of AmeriHealth Caritas Florida instructs the member to seek emergency services and care in accordance with s. 743.064, F.S. AmeriHealth Caritas Florida provides emergency services and care without any specified dollar limitations.

Emergency services and care under AmeriHealth Caritas Florida will not:

- Require prior authorization for a member to receive pre-hospital transport or treatment for emergency services or care.
- Specify or imply that emergency services and care are covered by AmeriHealth Caritas Florida only if secured within a certain period of time.
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.
- Deny payment based on a failure by the member or the hospital to notify AmeriHealth Caritas Florida before, or within a certain period of time after, emergency services and care were given.

AmeriHealth Caritas Florida covers pre-hospital and hospital-based trauma services and emergency services and care to members. When a member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists is to be made, for the purposes of treatment, by a provider of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital provider.

- The provider or the appropriate personnel must indicate on the member's chart the results of all screenings, examinations and evaluations.
- AmeriHealth Caritas Florida covers all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member's condition is an emergency medical condition.
- If the provider determines that an emergency medical condition does not exist, AmeriHealth Caritas Florida is not required to cover services rendered subsequent to the provider's determination unless authorized by the Plan.

If the provider determines that an emergency medical condition exists, and the member notifies the hospital, or the hospital emergency personnel otherwise have knowledge that the patient is a member of the Plan, the hospital must make a reasonable attempt to notify:

- The member's PCP, if known; or

- AmeriHealth Caritas Florida, if the Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

If the hospital, or any of its affiliated providers, do not know the member's PCP, or have been unable to contact the PCP, the hospital must:

- Notify AmeriHealth Caritas Florida as soon as possible before discharging the member from the emergency care area; or
- Notify AmeriHealth Caritas Florida within twenty-four (24) hours or on the next business day after the member's inpatient admission.

AmeriHealth Caritas Florida will cover any medically necessary duration of stay in a non-contracted facility that results from a medical emergency until such time as AmeriHealth Caritas Florida can arrange to safely transport the member to a participating facility. AmeriHealth Caritas Florida can transfer the member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the member's emergency medical condition.

Notwithstanding any other state law, a hospital may request and collect from a member any insurance or financial information necessary to determine if the patient is a member of AmeriHealth Caritas Florida, in accordance with federal law, so long as emergency services and care are not delayed by the process.

AmeriHealth Caritas Florida Standard Benefits

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|--|---|--|--|
| Addictions Receiving Facility Services | These services are used to help people who are struggling with drug or alcohol addiction and need hospitalization. | Covered ¹ | Yes |
| Allergy Services | Services to treat conditions such as sneezing or rashes that are not caused by an illness. | Covered ¹ <ul style="list-style-type: none"> • We cover blood or skin allergy testing and up to 156 doses per year of allergy shots. | No |
| Ambulance Transportation Services | Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities. | Covered ¹ | No — Emergency ground transportation while being transported to the hospital or special support when being transported between facilities. |
| Ambulatory Detoxification Services | Services provided to people who are withdrawing from drugs or alcohol without going into the hospital. | Covered ¹ | Yes |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|--|--|--|--|
| Ambulatory Surgical Center Services | Surgery and other procedures that are performed in a facility that is not the hospital (outpatient). | Covered ¹ | Yes — Cosmetic procedures only. |
| Anesthesia Services | Services to keep you from feeling pain during surgery or other medical procedures. | Covered ¹ | No |
| Assistive Care Services | Services provided to adults (ages 18 and older) help with activities of daily living and taking medication. | Covered ¹ <ul style="list-style-type: none"> • 365/366 days of service per year. | Yes |
| Behavioral Health Assessment Services | Services used to identify mental health or substance abuse issues. | Covered ¹ <ul style="list-style-type: none"> • One initial assessment per year • One reassessment per year • Up to 150 minute of brief behavioral health status assessments (no more than 30 minutes in a single day) | No |
| Behavioral Health Overlay Services | Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program. | Covered ¹ <ul style="list-style-type: none"> • We cover 365/366 days of medically necessary services per year, including therapy, support services and aftercare planning. | No |
| Cardiovascular Services | Services that treat the heart and circulatory (blood vessels) system, | Covered ¹ <ul style="list-style-type: none"> • Cardiac testing. • Cardiac surgical procedures. • Cardiac devices. | Yes — Radiology/ nuclear cardiac imaging only. |
| Child Health Services Targeted Case Management | Services provided to children (ages 0 - 3) to help them get health care and other services. OR Services provided to children (ages 0 – 20) | Covered ¹ <ul style="list-style-type: none"> • Child must be enrolled in the Department of Health Early Steps program. OR <ul style="list-style-type: none"> • Your child must be receiving medical foster care services. | No |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|---|--|--|--|
| | who use medical foster care services. | | |
| 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. | Covered ¹ <ul style="list-style-type: none"> • 24 patient visits per year. • X-rays. | Yes — Under age 21. |
| Clinic Services | Health care services provided in a county health department, federally qualified health center, or a rural health clinic. | Covered ¹ | No |
| Crisis Stabilization Unit Services | Emergency mental health services are performed in a facility that is not a regular hospital. | Covered ¹ | Yes – for emergency services only. Yes – for all other non-emergency services. |
| 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. | Covered ¹ <ul style="list-style-type: none"> • Hemodialysis treatments. • Peritoneal dialysis treatments. | No |
| Durable Medical Equipment and Medical Supplies Services | Medical equipment used to manage and treat a condition, illness, or injury. Durable medical equipment is used repeatedly, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away. | Covered ¹ <ul style="list-style-type: none"> • Some service and age limits apply. Call Member Services at 1-855-355-9800 (TTY 1-855-358-5856) for more information. | Yes — For medical equipment such as wheelchairs, braces, crutches, hospital-grade breast pumps, and other items. |
| Early Intervention Services | Services to children ages 0 – 3 who have developmental delays and other conditions. | Covered ¹ <ul style="list-style-type: none"> • One initial evaluation per lifetime, completed by a team. | No |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|------------------------------------|--|--|--|
| | | <ul style="list-style-type: none"> • Up to three screenings per year. • Up to three follow-up evaluations per year. • Up to two training or support sessions per week. | |
| Emergency Transportation Services | Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency. | Covered ¹ | <p>Yes — For airplane and helicopter emergency transportation.</p> <p>No — For ground emergency transportation and 911 transportation calls.</p> |
| Evaluation and Management Services | Services for doctor's visits to stay healthy and prevent or treat illness. | <p>Covered¹</p> <ul style="list-style-type: none"> • One adult health screening (check-up) per year. • Well-child visits are provided 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. | No |
| Family Therapy Services | Services for families to have therapy sessions with a mental health professional. | Covered ¹ | No |
| Gastrointestinal Services | Services to treat conditions, illnesses, or diseases of the stomach or digestive system. | Covered ¹ | No |
| Genitourinary Services | Services to treat conditions, illnesses, or diseases of the genitals or urinary system. | Covered ¹ | No |
| Group Therapy Services | Services for a group of people to have therapy sessions with a mental health professional. | Covered ¹ | No |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|-----------------------------|--|--|---------------------------------|
| Hearing Services | Hearing tests, treatments, and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs. | Covered ¹ <ul style="list-style-type: none"> • Hearing tests. • Cochlear implants. • One new hearing aid per ear, once every 3 years. • Repairs. | No |
| 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. | Covered ¹ <ul style="list-style-type: none"> • Up to four visits per day for pregnant members and members ages 0 – 20. • Up to three visits per day for all other members. | Yes |
| 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 ¹ <ul style="list-style-type: none"> • Member may have Patient Responsibility for hospice services whether living at home, in a facility, or in a nursing facility. | Yes |
| Individual Therapy Services | Services for people to have one-to-one therapy sessions with a mental health professional. | Covered ¹ | No |
| Inpatient Hospital Services | Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies, and treatments, visits from doctors, and equipment that is used to treat you. | Covered ¹ Based on age and situation: <ul style="list-style-type: none"> • Up to 365/366 days for members ages 0 – 20. • Up to 45 days for all other members (extra days are covered for emergencies). | Yes |
| Integumentary Services | Services to diagnose or treat skin conditions, illnesses, or diseases. | Covered ¹ | Yes — Cosmetic procedures only. |
| Laboratory Services | Services that test blood, urine, saliva, or other items from the body for | Covered ¹ | No |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
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| | conditions, illnesses or diseases. | | |
| Medical Foster Care Services | Services that help children with health problems who live in foster care homes. | Covered ¹ <ul style="list-style-type: none"> • Must be in the custody of the Department of Children and Families. | No |
| Medication Assisted Treatment Services | Services used to help people who are struggling with drug addiction. | Covered ¹ | No |
| Medication Management Services | Services to help people understand and make the best choices for taking medication. | Covered ¹ | No |
| Mental Health Partial Hospitalization Program Services | Treatment provided for 4 or more hours per day, several days per week, for people who are recovering from mental illness. | Covered ¹ | No |
| Mental Health Targeted Case Management | Services to help get medical and behavioral health care for people with mental illnesses. | Covered ¹ | No |
| Mobile Crisis Assessment and Intervention Services | A team of health care professionals who provide emergency mental health services, usually in people's homes. | Covered ¹ | No |
| Neurology Services | Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord, or nervous system. | Covered ¹ | No |
| Non-Emergency Transportation Services | Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kind of vehicle. | Covered ¹ For members who have no transportation: <ul style="list-style-type: none"> • Out-of-state travel. • Transfers between hospitals or facilities. | No — Please call 1-855-371-3968 (TTY 711) to schedule non-emergency transportation services. |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|-------------------------------|--|---|---------------------------------|
| | | <ul style="list-style-type: none"> Escorts when medically necessary. | |
| Nursing Facility Services | Medical care or nursing care that you get while living fulltime in a nursing facility. This can be a short-term rehabilitation stay or long-term. | Covered ¹ <ul style="list-style-type: none"> 365/366 days of services in nursing facilities. See information on Patient Responsibility for room and board copayment information. | Yes |
| Occupational Therapy Services | Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house. | Covered ¹ For children ages 0 –20 and for adults: <ul style="list-style-type: none"> One initial evaluation per year. Up to 210 minutes of treatment per week. One initial wheelchair evaluation per 5 years For people of all ages: <ul style="list-style-type: none"> Follow-up wheelchair evaluations, one at delivery and one 6 months later. | Yes |
| Oral Surgery Services | Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity. | Covered ¹ | Yes — Cosmetic procedures only. |
| Orthopedic Services | Services to diagnose or treat conditions, illnesses or diseases of the bones or joints. | Covered ¹ | No |
| Outpatient Hospital Services | Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits | Covered ¹ | Yes — Depending on procedure |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
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| | from doctors, and equipment that is used to treat you. | | |
| Pain Management Services | Treatments for long-lasting pain that does not get better after other services have been provided. | Covered ¹ <ul style="list-style-type: none"> Some service limits may apply. | Yes |
| 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. | Covered ¹ For children ages 0 –20 and for adults: <ul style="list-style-type: none"> One initial evaluation per year. Up to 210 minutes of treatment per week. One initial wheelchair evaluation per 5 years. For people of all ages: <ul style="list-style-type: none"> Follow-up wheelchair evaluations, one at delivery and one 6 months later. | Yes |
| Podiatry Services | Medical care and other treatments for the feet. | Covered ¹ <ul style="list-style-type: none"> 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. | No |
| Prescribed Drug Services | This service is for drugs that are prescribed to you by a doctor or other health care provider. | Covered ¹ <ul style="list-style-type: none"> Up to a 34-day supply of drugs, per prescription. Refills, as prescribed. | Refer to online Preferred Drug Listing www.amerhealthcaritasfl.com |
| Private Duty Nursing Services | Nursing services provided in the home to people ages 0 – 20 who need constant care. | Covered ¹ <ul style="list-style-type: none"> Up to 24 hours per day. | Yes |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|---|--|--|--|
| Psychiatric Specialty Hospital Services | Emergency mental health services that are performed in a facility that is not a regular hospital. | Covered ¹ | No – for emergency services only. Yes – for all other non-emergency services. |
| Psychological Testing Services | Tests used to identify behavioral health problems. | Covered ¹ | Yes |
| 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. | Covered ¹ • Up to 480 hours per year | No |
| Radiology and Nuclear Medicine Services | Services that include imaging such as X-rays, MRIs, or CAT scans. They also include portable X-rays. | Covered ¹ | Yes – For CT, MRI, MRA, PET scans and nuclear cardiac imaging. No – For X-rays and portable X-rays when done by a participating provider. |
| 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 ¹ | Yes |
| 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 you plan the size of your family. | Covered ¹ 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. Members do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if they are younger than 18 years old. | No |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|--|---|---|---------------------|
| Respiratory Services | Services that treat conditions, illnesses or diseases of the lungs or respiratory system. | Covered ¹ <ul style="list-style-type: none"> • Respiratory testing. • Respiratory surgical procedures. • Respiratory device management. | Yes |
| Respiratory Therapy Services | Services for members ages 0 –20 to help you breathe better while being treated for a respiratory condition, illness or disease. | Covered ¹ <ul style="list-style-type: none"> • One initial evaluation per year. • One therapy re-evaluation per 6 months. • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day). | Yes |
| Self-Help/Peer Services | Services to help people who are in recovery from an addiction or mental illness. | Covered ¹ | No |
| Specialized Therapeutic Services | Services provided to children ages 0 –20 with mental illnesses or substance use disorders. | Covered ¹ <ul style="list-style-type: none"> • Assessments. • Foster care services. • Group home services. | No |
| Speech- Language Pathology Services | Services that include tests and treatments help you talk or swallow better. | Covered ¹ For children ages 0 – 20: <ul style="list-style-type: none"> • Communication devices and services. • Up to 210 minutes of treatment per week. • One initial evaluation per year. For adults: <ul style="list-style-type: none"> • One communication evaluation per 5 years. | Yes |
| Statewide Inpatient Psychiatric Program Services | Services for children with severe mental illnesses who need treatment in a facility. | Covered ¹ <ul style="list-style-type: none"> • Children ages 0 – 20 | Yes |

| Service | Description | Coverage/Limitations (Member may have to pay for these services if you see a provider who is not in the AmeriHealth Caritas Florida network) | Prior Authorization |
|--|---|---|---------------------|
| Therapeutic Behavioral On- Site Services | Services provided by a team to prevent children ages 0 –20 with behavioral health issues from being placed in a hospital or other facility. | Covered ¹ | No |
| Transplant Services | Services that include all surgery and pre- and post- surgical care. | Covered ¹ | Yes |
| Visual Aid Services | Visual aids are items such as glasses, contact lenses, and prosthetic (fake) eyes. | Covered ¹ <ul style="list-style-type: none"> • Two pairs of eyeglasses for children ages 0 – 20 • One frame every two years and two lenses every 365 days age 21 and over. Contact lenses. • Prosthetic eyes. | No |
| Visual Care Services | Services that test and treat conditions, illnesses and diseases of the eyes. | Covered ¹ | No |
| Waived Copayments | Member will not have any copayments on any health plan services. | Covered ¹ All services that have a copayment requirement in accordance with Rule 59G-1.056, FAC. | No |

¹These medical services are covered, as medically necessary, by AmeriHealth Caritas Florida. AmeriHealth Caritas Florida members may need a referral from you before going to an appointment or using a service. Services must be medically necessary in order for AmeriHealth Caritas Florida to pay for them.

AmeriHealth Caritas Florida Expanded Benefits

Expanded benefits are AHCA-approved services that are additional benefits specified in the AHCA contract. These expanded benefits may be subject to medical necessity and prior authorization.

The following expanded benefits are available to AmeriHealth Caritas Florida members:

| Service | Description | Coverage/Limitations You may have to pay for the services if you go to a provider that is not in the AmeriHealth Caritas Florida network | Prior Authorization |
|--|--|---|---------------------|
| Acupuncture | A treatment that is used to treat pain. | Covered ¹ • Annual maximum of 12 visits for members with acute and chronic pain. | No |
| Adult Hearing Services | Adult hearing services including hearing aids. | Covered ¹ • One hearing aid and evaluation every two years. | Yes |
| Adult Vision Services | Adult vision services including eyeglasses and contact lenses. | Covered ¹ • One eye exam per year; six-month supply of contact lenses with prescription or one set of eyeglasses per year. | Yes |
| Assessment Services | In-depth assessment for substance use issues. | Covered ¹ , no limit. | No |
| | Psychological testing to identify behavioral health problems. | Covered ¹ , no limit. | Yes |
| Behavioral Health Day Services/Day Treatment | Daytime treatment for behavioral health needs about everyday living. | Covered ¹ , no limit • Must be active in case management, for members age 21 and over. | No |
| | Adult day care services. | Covered ¹ , no limit. • Must be active in case management, for members age 21 and over. | No |
| Behavioral Health Screening Services | Assessments and screening services for mental health and substance use issues. | Covered ¹ , no limit. | No |
| Behavioral Health Medical Services (Verbal Interaction) | Talking with a medical professional about your mental health and/or substance use needs. | Covered ¹ , no limit. | No |
| Behavioral Health Medical Services (Medication Management) | Services with a medical professional who can treat mental health and substance use issues with medication. | Covered ¹ , no limit. | No |
| Behavioral Health Medical Services (Drug Screening) | Alcohol and other drug screening with urine samples. | Covered ¹ , no limit. | No |

| Service | Description | Coverage/Limitations You may have to pay for the services if you go to a provider that is not in the AmeriHealth Caritas Florida network | Prior Authorization |
|--|---|---|---|
| Biometric Equipment | Members can request biomedical equipment to help support their health: <ul style="list-style-type: none"> • Blood pressure monitor/cuff • Weight scale | One digital blood pressure cuff every three years. One weight scale every three years. For members in a care management program. | No |
| Cellular Phone Service | This benefit can help members stay in touch with AmeriHealth Caritas Florida or their providers. | Covered ¹ <ul style="list-style-type: none"> • One smartphone; monthly call minutes and data; unlimited text messages; unlimited calls to AmeriHealth Caritas Florida Member Services. (One per household for members 18 and older. Certain limitations may apply based on FCC guidelines.) | No |
| Chiropractic | Services and treatment provided by a chiropractic provider. | Covered ¹ <ul style="list-style-type: none"> • Expanded benefit covers 24 additional visits for a total of 48 visits per year. | No |
| Computerized Cognitive Behavioral Analysis | Health and behavior assessments and reassessments (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires). | Covered ¹ , no limit | No |
| | Family health and behavior intervention; family (without the patient present). | Covered ¹ , no limit | No |
| Doula Services | Pregnancy services done by providers who are trained in childbirth and give support and | Covered ¹ , no limit <ul style="list-style-type: none"> • For pregnant members. | No, but requires a referral from plan's Bright Start maternity program. |

| Service | Description | Coverage/Limitations You may have to pay for the services if you go to a provider that is not in the AmeriHealth Caritas Florida network | Prior Authorization |
|---|---|---|---------------------|
| | education to pregnant members. | | |
| Flu/Pandemic Prevention Kit | Members can request flu/pandemic kits with helpful care items. | One flu/pandemic prevention kit includes ten face masks, an oral digital thermometer, and hand sanitizer. Annual limit of six kits; care manager referral needed. | No |
| Home Delivered Meals - General | If a member is part of an eligible care management program, they may be able to have meals delivered to their home. | For members who meet program guidelines for medical necessity. Up to two meals per day for 30 days. Extension of services may be granted with medical director approval. | Yes |
| Home Delivered Meals for High-Risk Pregnant Members | Meals delivered at home if provider believes this is a high-risk pregnant member. | Covered ¹ <ul style="list-style-type: none"> Up to two meals per day for 30 days; limited to high-risk pregnant members. | Yes |
| Home Delivered Meals – Post-Discharge | Meals delivered to members’ home after leaving a medical facility. | Covered ¹ <ul style="list-style-type: none"> Up to two meals per day for up to seven days for members that have been recently discharged from the hospital with specific medical conditions. Extension of services may be granted with medical director approval. | Yes |
| Home Health Nursing/Aide Services | Services that can help with activities of daily living like bathing, getting dressed, and eating. | Covered ¹ <ul style="list-style-type: none"> Provide up to an additional 48 visits per pregnancy for home health aide; limited to high-risk pregnant members who meet plan guidelines for medical necessity; requires a physician order. | Yes |
| Home Visit by a Clinical Social Worker | Services to provide support and education that will help to improve the quality of life for | Covered ¹ <ul style="list-style-type: none"> Limited to 24 visits per year for high-risk pregnant members; requires physician order. | Yes |

| Service | Description | Coverage/Limitations You may have to pay for the services if you go to a provider that is not in the AmeriHealth Caritas Florida network | Prior Authorization |
|---|---|---|--|
| | high-risk pregnant moms. | | |
| Housing Assistance | Provide help to high-risk pregnant members in finding community resources to help with housing. | Covered ¹ <ul style="list-style-type: none"> Assistance with locating community resources that support housing options and alternatives for all members; provides up to \$500 per lifetime max for transitional housing alternatives; financial assistance is limited to high-risk pregnant members who are homeless. | Yes |
| Intensive Outpatient Treatment | Outpatient treatment services in a program for substance use that meets three days per week for three hours each day. | Covered ¹ <ul style="list-style-type: none"> 25 sessions per year for members age 21 and over | Yes |
| Massage Therapy | Therapy that is used for the treatment of pain. Commonly, massage is applied with a therapist's hands and fingers. | Covered ¹ <ul style="list-style-type: none"> Annual maximum of 12 visits for medical massage provided by a participating physical therapy or chiropractic provider. | Prior authorization required for physical therapist. No prior authorization needed for chiropractor. |
| Meals During Non-emergency Transportation Day-Trips | Reimbursement for the cost of meals when traveling away from home for a medical appointment. | Covered ¹ <ul style="list-style-type: none"> Limited to \$50 per day with annual maximum of \$250. | Yes |
| Medical Supplies | Medical supplies are items meant for one-time use and then thrown away. | Covered ¹ <ul style="list-style-type: none"> Some service limits apply. | Yes |
| | Incontinence products. | Covered ¹ | Yes – needs case management referral |

| Service | Description | Coverage/Limitations You may have to pay for the services if you go to a provider that is not in the AmeriHealth Caritas Florida network | Prior Authorization |
|--------------------------------------|---|--|----------------------------------|
| | | <ul style="list-style-type: none"> • 200 units per month; any combination of these codes can be billed, but only up to 200 units. | |
| Medically Related Home Care Services | Carpet cleaning service that will help members control their asthma. | Covered ¹ <ul style="list-style-type: none"> • Two carpet cleanings for members age 21 and over with an annual maximum of \$200. Must be active in care management. Service must be from the approved vendor list. | Yes |
| Medication Assisted Treatment | A licensed program that gives medication to lessen withdrawal symptoms from drugs or alcohol, along with supportive counseling. | Covered ¹ , no limit. | No |
| Newborn Circumcision | An elective surgery for baby boys. | Covered ¹ <ul style="list-style-type: none"> • Available during initial hospital stay and in physician's office for 90 days after birth. | Yes, only if older than 90 days. |
| Nutritional Counseling | Provides you with information about what foods are good for you and your health condition. These services can also help you with food shopping and ways to prepare these foods at home. | Covered ¹ , no limit. | No |
| Occupational Therapy | Adult occupational therapy services. | Covered ¹ <ul style="list-style-type: none"> • One initial evaluation and re-evaluation per year; up to seven therapy treatment units per week. | Yes |
| Over-The-Counter Medication/Supplies | Provides health supplies and items such as aspirin, vitamins, first aid items, and cough medicine. | Covered ¹ <ul style="list-style-type: none"> • \$25 per household per month; purchases limited to approved products. | No |

| Service | Description | Coverage/Limitations You may have to pay for the services if you go to a provider that is not in the AmeriHealth Caritas Florida network | Prior Authorization |
|---|---|--|---------------------|
| Physical Therapy | Adult physical therapy services. | Covered ¹ • One evaluation and re-evaluation visit per year; up to seven therapy treatments per week. | Yes |
| Prenatal/ Perinatal Visits | Pregnancy visits before and after giving birth, | Covered ¹ , no limit. | Yes |
| Primary Care Visits (Non-Pregnant Adults) | Visits with your PCP. | Covered ¹ , no limit. | No |
| Respiratory Therapy | Adult respiratory therapy services. | Covered ¹ • One evaluation and re-evaluation per year; respiratory therapy visits one per day. | No |
| Speech Therapy | Adult speech therapy services. | Covered ¹ • One evaluation visit per year. | No, for evaluation |
| Swimming Lessons (drowning prevention) | Provides swimming and water safety lessons for children to keep them safe around water. | Covered ¹ • Each April, there will be an open enrollment for up to 1,000 children from 6 months to 12 years of age. Up to \$200 per member will be paid to a plan-approved agency or certified instructor. | Yes |
| Therapy (Art) | Art uses creative activities, such as drawing and painting as part of treatment. | Covered ¹ • Up to seven outpatient sessions per year; 21 years and older. | Yes |
| Therapy (Equine) | Uses horseback riding with a behavioral health professional as part of treatment. | Covered ¹ • Up to three outpatient sessions per year for members with a substance use disorder or chronic condition under care management; 21 years and older. | Yes |
| Therapy (group) | Therapy for a group of people with a mental health professional. | Covered ¹ , no limit. | No |

| Service | Description | Coverage/Limitations You may have to pay for the services if you go to a provider that is not in the AmeriHealth Caritas Florida network | Prior Authorization |
|---|---|---|---------------------|
| Therapy (individual/family) | Training and educational services about how to care for the member's disabling mental health problems. | Covered ¹ , no limit for individual. Family limited to 20 quarter hour units per day for members age 21 and over. | No |
| Therapy (Pet) | Certified handlers and their pets help with treatment or therapy. | Covered ¹ <ul style="list-style-type: none"> • Unlimited visits for adults age 21 and older, under care management. Limited to rehabilitative purposes. Services must be provided by a certified pet handler or licensed by the Art Therapies Credentials board. | Yes |
| Therapeutic Behavioral On-Site Services | Services provided by a team to support behavioral health issues and keep you from being placed in a hospital or other facility. | Covered ¹ <ul style="list-style-type: none"> • 2 visits per provider per year for members age 21 and over | No |
| Targeted Case Management | Help with getting health care and behavioral health services. | Covered ¹ <ul style="list-style-type: none"> • Members age 21 and over | No |
| Tutoring K-12/GED Support Program | Members can get coaching and testing support to obtain a GED. | Mission GED program provides resources and coaching support to obtain a General Equivalency Diploma (GED). The program includes class sign-up, test site location, registration, and goal identification. The program covers the cost of the exam(s) for all subjects. Available to members between the ages of 16-50. Health plan staff referral needed. | No |
| Vaccine — TDaP | A vaccine to help keep pregnant moms healthy during their pregnancy. | Covered ¹ <ul style="list-style-type: none"> • One vaccine per pregnancy. | No |

| Service | Description | Coverage/Limitations You may have to pay for the services if you go to a provider that is not in the AmeriHealth Caritas Florida network | Prior Authorization |
|---|--|--|---------------------|
| Vaccine — Influenza | A vaccine to help reduce the chance of getting the flu. | Covered ¹ <ul style="list-style-type: none"> One vaccine per year, per member. | No |
| Vaccine — Shingles (Varicella – Zoster) | A vaccine to help reduce the chance of getting shingles. | Covered ¹ <ul style="list-style-type: none"> Adult members who have had chickenpox and as medically advised. | No |
| Vaccine — Pneumonia (pneumococcal) | A vaccine to help reduce the chance of getting pneumonia. | Covered ¹ <ul style="list-style-type: none"> Two vaccines for all members aged 65 and older and members ages 21 – 64 with specific medical conditions in accordance with current Centers for Disease Control and Prevention (CDC) immunization schedule; vaccines must be given at least one year apart. | No |
| Waived Copayments | Member will not have any copayments on any health plan services. | Covered ¹ <ul style="list-style-type: none"> All services that have a copayment requirement in accordance with Rule 59G-1.056, FAC. | No |

¹These medical services are covered, as medically necessary, by AmeriHealth Caritas Florida. AmeriHealth Caritas Florida members may need a referral from you before going to an appointment or using a service. Services must be medically necessary in order for AmeriHealth Caritas Florida to pay for them.

Chapter 6: Credentialing

Credentialing Requirements

AmeriHealth Caritas Florida operates in compliance with the standards set forth by the National Committee for Quality Assurance, the Agency for Health Care Administration and federal and state regulations. Our credentialing standards mandate that we credential providers before they join the AmeriHealth Caritas Florida provider network and prior to offering healthcare services to AmeriHealth Caritas Florida members, and no later than 36 months thereafter.

Per Florida requirements, to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time services are rendered. Any entity that bills Medicaid for Medicaid-compensable services provided to Medicaid recipients or that provides billing services of any kind to Medicaid providers must enroll as a Medicaid provider. This includes solo practitioners practicing under a corporation.

Any provider and/or billing entity with a Medicaid agreement other than Limited or Fully Enrolled with the Agency may be subject to additional credentialing requirements such as Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.1 05) and conviction of crimes (42 CFR 455.1 06); and Level 2 background check pursuant to s. 409.907, F.S.

To enroll in Medicaid visit:

https://portal.flmmis.com/FIpublic/Provider_ProviderServices/Provider_Enrollment/Provider_Enrollment_EnrollmentApplication/tabid/67/desktopdefault+/Default.aspx.

If the provider is currently suspended or terminated from Florida Medicaid whether by contract or sanction, other than for purposes of inactivity, that provider is not considered eligible to participate as an AmeriHealth Caritas Florida provider.

Criteria and verification methodology used by AmeriHealth Caritas Florida is designed to credential and re-credential in a non-discriminatory manner, with no attention to a provider's race, creed, religion, ethnicity, national origin, gender, age, disability, sexual orientation, political affiliation or beliefs, or specialty and procedures performed.

To initiate credentialing or re-credentialing, the process starts with one of the options below:

Practitioners:

Council for Affordable Quality Healthcare (CAQH) providers:

- If you participate with CAQH, you will need to grant AmeriHealth Caritas Florida access to your application. Please make sure the information on your application is current.
- In addition to the CAQH application, AHCA requires health plans to collect additional information included in the AmeriHealth Caritas Florida supplemental form for CAQH applicants. To request the supplemental application, please contact us by e-mail credentialingsupport@amerihealthcaritasfl.com or fax to 1-866-930-4632.

Non-CAQH providers:

- If you do not participate with CAQH, you must register by calling the CAQH Provider Help Desk at **1-888-599-1771** or at <https://proview.caqh.org>. Once you have registered with CAQH, you will need to grant AmeriHealth Caritas Florida access to your application.

Your CAQH application must be current at the time of credentialing and have these documents:

- Medical license.
- Copy of Drug Enforcement Administration license (when applicable).
- Professional liability insurance or proof of meeting other state requirements.

- Clinical Laboratory Improvement Amendments number (when applicable).
- A current group W-9 form (not older than 12 months).
- A correct and active Practitioner and Group National Provider Identifier.
- At least five years of employment history by month and year, as well as an explanation for any gaps of employment six months or greater.
- For any question answer “YES” on section #8 of the CAQH application, include a written explanation of the event indicated. This explanation should include dates, description of events, outcomes and any settlements or payments made by the provider or on his/her behalf.
- A site visit is required for all practitioners. Credentialing cannot start until a site visit is conducted. Contact your account executive to schedule a site visit evaluation.

Organizational providers -- i.e. facility/ancillary providers:

- Complete an AmeriHealth Caritas Florida application.
- Any answers marked “Yes” on the Disclosure Questionnaire of the application must be accompanied by a written description of the event indicated. This explanation should include dates, description of events, outcomes, and any settlements or payments made by the provider or on its behalf.

Your application must be sent with a copy of these documents:

- An attestation of the correctness and completeness of the information supplied.
- Current copy of state license for each address (when applicable).
- Copy of certificate of accreditation (when applicable).
- Copy of Clinical Laboratory Improvement Amendments license (when applicable).
- Copy of Drug Enforcement Administration license (when applicable).
- A current W-9 form (not older than 12 months).
- Evidence of Medicaid eligibility.
- Active Medicaid Number/Enrollment/Certification.
- Current copy of the general and malpractice liability insurance. This document must indicate the current facility name and address.
- Documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid Sanctions, or loss, limitation, or cancellation of professional liability insurance.
- Ownership Disclosure Form.
- If the organizational provider does not have accreditation or a CMS State Survey or letter from CMS, or if the most recent survey is older than 3 years old, a plan site visit may be performed.

Credentialing Committee

The AmeriHealth Caritas Florida Credentialing Committee uses a peer review process to evaluate practitioner and organizational provider applications, and credentials to determine appropriateness for participation in the AmeriHealth Caritas Florida network. The Committee includes representation from a range of participating practitioners representing primary care providers, specialists, and allied health practitioners in AmeriHealth Caritas Florida’s network.

The Credentialing Committee may make one of the following determinations:

- Credentialing application approved, with or without restriction.
- Credentialing application denied may include, but not be limited to:
 - Limited or loss of license;
 - Change in Medicaid status;
 - Loss of sufficient liability coverage;
 - Fraud or felony investigation; and/or

- Adverse information related to quality of care or service concerns.

Notification of the Credentialing Committee's decision is sent to the provider within sixty (60) calendar days of the decision. In the case of a denial or terminations, the notification is sent within the timeframe required by contract, state regulation or accreditation body.

Re-credentialing

AmeriHealth Caritas Florida network providers are re-credentialed every 36 months. The Credentialing Department will start the re-credentialing processes prior to the provider's re-credentialing due date. Re-credentialing requirements are the same as during the initial credentialing as noted above. However, re-erification of network provider education, training and work history are not required elements for collection at the time of re-credentialing.

A new site inspection evaluation conducted by an AmeriHealth Caritas Florida network account executive may be required for any ancillary/facility that does not have an accreditation or is not Medicare certified or does not have an AHCA certificate. In some circumstances, re-credentialing may not proceed until the site inspection evaluation is conducted. Contact your account executive to schedule a site inspection. For all other providers, AmeriHealth Caritas Florida may repeat the site visit as deemed necessary.

If AmeriHealth Caritas Florida cannot re-credential a provider within the 36-month time frame due to active military assignment, maternity leave or a sabbatical, but the contract between AmeriHealth Caritas Florida and the provider remains in place, we may re-credential the provider upon his or her return. The provider must provide documentation for the reason(s) of the delay.

Right to Review and Correct Information

The provider has the following rights:

- The right to review information submitted to support their credentialing application. This includes any information submitted by the Provider or any outside information obtained through primary source verification, with the exception of references, recommendations, or other peer-review protected information.
- The right to correct erroneous information.
- The right, upon request, to be informed of the status of their credentialing or re-credentialing application.

Right to appeal adverse credentialing determinations:

If a provider or organizational provider's application is terminated from participation during the re-credentialing process, the practitioner or organizational provider may appeal or dispute the termination. Denial of participation into the AmeriHealth Caritas Florida network during initial credentialing does not have appeal rights.

In the case AmeriHealth Caritas Florida denies or terminates a provider during credentialing or re-credentialing, a notification will be sent to the provider within the timeframe required by contract, state regulation or accreditation body. The notification will include the reason for the decision, notification of the right to appeal the action (when applicable, i.e. re-credentialing), and time frames regarding response for a request to appeal the decision.

Chapter 7: Provider Responsibilities

In accordance with Attachment B, Section IX.G.1.a-f, and Exhibit B-1, Section IX.G.1.a-c of the AHCA Contract, s. 641.55, Florida Statutes, and s. 59A-12.012, Florida Administrative Code, providers and subcontractors are required to report adverse incidents or injuries affecting members to AmeriHealth Caritas Florida immediately upon the incident occurrence, and no later than forty-eight (48) hours of detection or notification.

AmeriHealth Caritas Florida subcontractors are also required to complete an Adverse Incident Summary Report for the previous month's incidents, involving AmeriHealth Caritas Florida members. The report shall be submitted to AmeriHealth Caritas Florida's Risk Management Department by the 5th of each month.

Primary Care Providers (PCP)

The AmeriHealth Caritas Florida model of care centers on the individual member with a direct connection to a primary care provider. Primary care providers are defined as individual practitioners who provide primary care services and manage routine healthcare needs. A Primary Care Provider is a participating provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to a member. Primary care physician relationships are critical to sustained, comprehensive, and coordinated medical care

Our PCPs are the foundation of AmeriHealth Caritas Florida. The PCP serves as the "medical home" for the member. The member is allowed to change their PCP as frequently as desired. The "medical home" concept assists in establishing a member/ provider relationship, supports continuity of care, leads to elimination of redundant services and ultimately more cost effective care and better health outcomes.

AmeriHealth Caritas Florida's Patient-Centered Medical Home (PCMH) is built upon the principles which includes the following characteristics: a primary care provider adopting a "whole person" orientation; coordinated and/or integrated care based on physical and behavioral health needs; taking into account members' socioeconomic conditions and cultural norms; quality and safety; and enhanced access to care. AmeriHealth Caritas Florida accepts PCMH recognition from Association for Ambulatory Health Care (AAHC). If a practice is interested in becoming a PCMH they can contact Provider Services at **1-800-617-5727**.

Covered PCP Services

The PCP is required to adhere to the responsibilities outlined as follows:

The PCP is responsible for supervising, coordinating, and providing all primary care to each assigned member. In addition, the PCP is responsible for coordinating and/or initiating referrals for specialty care (both in and out of network), maintaining continuity of each member's healthcare and maintaining the member's medical record. This includes documentation of all services provided by the PCP, any specialty services, and screening for behavioral health or substance use disorders. The PCP shall arrange for other participating physicians to provide members with covered physician services as stipulated in their contract, and communicate with those treating providers. Each participating PCP provides all covered physician services in accordance with generally accepted clinical, legal, and ethical standards in a manner consistent with practitioner licensure, qualifications, training, and experience. These standards of practice for quality care are generally recognized within the medical community in which the PCP practices.

Covered services include:

- Professional medical services, both inpatient and outpatient, provided by the PCP, nurses, and other personnel employed by the PCP. These services include the administration of immunizations, but not the cost of biologicals.

- Periodic health assessments and routine physical examinations (performed at the discretion of the PCP, and consistent with AHCA, AmeriHealth Caritas Florida’s preventive guidelines, and other nationally recognized standards recommended for the age and sex of the covered person).
- Vision screening, hearing screenings, and dental assessment (as part of well-child visit).
- High cost specialty/injectable drugs, as listed on the prior authorization list, require a prior authorization and must be obtained from AmeriHealth Caritas Florida to ensure payment. Please call the AmeriHealth Caritas Florida Pharmacy Department at **1-855-371-3963** to obtain more detailed information on these drugs.
- All tests routinely performed in the PCP’s office during an office visit.
- The collection of laboratory specimens.
- Voluntary family planning services such as examinations, counseling, and pregnancy testing.
- Well-child care and periodic health appraisal examinations, including all routine tests performed customarily in a PCPs office. Well-child exams performed according to the EPSDT periodicity schedule, AmeriHealth Caritas Florida’s preventive guidelines, and recommendations of the American Academy of Pediatrics, and immunizations according to the Advisory Committee on Immunization Practices guidelines and in keeping with procedures outlined in this provider manual.
- Referral to specialty care physicians and other health providers with coordination of care, follow-up after referral.
- Oversight of a member’s entire drug regimen, including those prescribed by another provider, inclusive of behavioral health providers.
- PCPs supervision of home care/home infusion regimens involving ancillary health professionals provided by licensed nursing agencies.
- Any other outpatient services and routine office supplies normally within the scope of the PCPs practice.
- A treatment plan developed collaboratively with member, member’s parent or legal guardian, or other member authorized person and other treating specialists, as appropriate. This includes members seen for routine care or monitoring and those who need an extended or complex course of treatment.
- Health risk assessments will include screening for tobacco use, providing cessation counseling, body mass index, nutrition, exercise or other lifestyle risks. In addition, anticipatory guidance based on age of member – normal growth and development, seat belt, substance use.
- Assessments for gaps in preventive health screenings or visits along with the evidence based treatment of chronic conditions.
- Identification and referral of members who could benefit from AmeriHealth Caritas Florida’s casemanagement, health management, or lifestyle coaching programs.
- Provider shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number **1-800-96ABUSE (1-800-962-2873)**. Provider warrants and represents that staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect and exploitation. Provider agrees to participate in any other training as mandated by regulatory authorities and/or AmeriHealth Caritas Florida.

PCP Availability

Availability is defined as the extent to which AmeriHealth Caritas Florida contracts with the appropriate type and number of PCPs necessary to meet the needs of its members within defined geographical areas. AmeriHealth Caritas Florida has implemented several processes to monitor its network for sufficient types and distribution of PCPs.

PCP availability is analyzed annually by AmeriHealth Caritas Florida. AmeriHealth Caritas Florida computes the percentage of PCPs with panels open for new members versus those PCPs accepting only members who are already existing patients in their practice. The Member Services department analyzes member surveys and member complaint data to address AHCA and federal requirements regarding the cultural, ethnic, racial, and linguistic needs of the membership. The Quality

Improvement department tracks and trends member and provider complaints quarterly and monitors other data (such as appointment availability audits, after-hours use of the member hotline and member and provider satisfaction surveys) that may indicate the need to increase network capacity. Practice specific data is shared with the Credentialing Committee bi-annually as part of ongoing monitoring.

Summary information is reported to the Quality Improvement Committee for review and recommendation and is incorporated into AmeriHealth Caritas Florida’s annual assessment of quality improvement activities. The Quality Improvement Committee will review the information for opportunities for improvement.

PCP Accessibility

Accessibility is the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. AmeriHealth Caritas Florida monitors access to services by performing access audits, tracking applicable results of the Consumer Assessment of Healthcare Provider Systems Survey (CAHPS®), analyzing member complaints regarding access, and reviewing telephone access.

24-Hour Access

Each PCP is responsible for maintaining sufficient facilities and personnel to provide covered physician services and shall ensure that such services are available as needed 24 hours a day, 365 days a year. This coverage must consist of an answering service, call forwarding, provider call coverage or other customary means. The chosen method of 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hour coverage must be accessible using the medical office’s daytime telephone number. The PCP or covering medical professional must return the call within 30 minutes of the initial contact.

AmeriHealth Caritas Florida will monitor physicians’ offices through phone calls and scheduled and unscheduled visits.

PCP Coverage

The PCP shall arrange for coverage with a physician who has executed a PCP Services Agreement with AmeriHealth Caritas Florida. If the participating physician is capitated for primary care services, compensation for the covering physician is considered to be included in the capitation payment. If the participating physician is paid a fee-for-service by AmeriHealth Caritas Florida, the covering physician is compensated in accordance with the contracted fee schedule.

The PCP is responsible for arranging coverage of primary care services during absences due to vacation, illness or other situations that render the PCP unable to provide services. A Medicaid-eligible PCP must provide coverage.

Appointment Access Standards

AmeriHealth Caritas Florida monitors the following access standards on an annual basis per Medicaid managed care guidelines.

| General Appointment Scheduling for PCPs and Specialists | |
|---|--|
| Urgent PCP Appointment | Within forty-eight (48) hours of a request |
| Routine PCP Appointment | Within thirty (30) days of a request |
| Specialist Appointment | Within sixty (60) days of a request |
| Initial BH Appointment | Within fourteen (14) days of a request |
| BH Post Discharge Appointment | Within seven (7) days post discharge from an inpatient behavioral health admission for follow- up behavioral treatment |

Emergency services must be provided immediately upon presentation, twenty-four hours a day, seven days a week (24/7).

Missed Appointment Tracking

If a member misses an appointment with a provider, the provider must document the missed appointment in the member's medical record. Providers must make at least three (3) documented attempts to contact the member and determine the reason. The medical record should reflect any reasons for delays in performing the examination and should also include any refusals by the member.

Access to After-Hours Care

AmeriHealth Caritas Florida members will have access to quality, comprehensive health care services twenty-four hours a day, seven days a week (24/7). PCPs must have either an answering machine or an answering service for members during after-hours for non-emergent issues. The answering service must forward calls to the PCP or on-call provider, or instruct the member that the provider will contact the member within thirty (30) minutes. When an answering machine is used after-hours, the answering machine must provide the member with a process for reaching a provider after-hours. The after-hours coverage must be accessible using the medical office's daytime phone number.

For emergent issues, both the answering service and answering machine must direct the member to call **911** or go to the nearest emergency room. AmeriHealth Caritas Florida will monitor access to after-hours care by conducting a survey of PCP offices after normal business hours.

Monitoring Appointment Access and After-Hours Access

AmeriHealth Caritas Florida monitors appointment waiting times using various mechanisms, including:

- Reviews conducted by account executives during routine visits.
- Reviewing provider records during the initial and triennial facility site review.
- Monitoring administrative complaints and grievances.
- Conducting an annual access to care survey to assess member access to daytime appointments and after-hours care.
- Non-compliant providers will be subject to corrective action and/or termination from the network.
- A non-compliance letter will be sent to the provider.

Telephone Arrangements

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the member's telephone inquiries on a timely basis.
- Response time for telephone call-back waiting times:
 - After hours telephone care within 30 minutes.
 - Same day for non-symptomatic concerns.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling cancelled and no-show appointments.
- Identifying special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, or for non-compliant individuals or those people with cognitive impairments).
- Scheduling continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours, protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other satisfactory method, and then transferred to the member's medical record.

Note: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

Referrals

Case managers determine the need for non-covered services and referral of the member for assessment and referral to the appropriate service setting (to include referral to the Special Supplemental Nutrition Program for Women, Infants, and Children) with assistance, as needed, by the area Medicaid office.

AmeriHealth Caritas Florida ensures that case managers are required to provide community referral information on available services and resources to meet the needs of members.

If a service is closed because AmeriHealth Caritas Florida has determined that it is no longer medically necessary, the member must be given a written Notice of Action regarding the intent to discontinue the service that contains information about his/her rights with regards to that decision.

PCPs coordinate member healthcare services. Members are allowed to self-refer for certain services (see below). PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of the PCP. This includes referral to behavioral health providers. Those referrals do not require authorization. For out of network referrals see information described herein. Providers are required to notify AmeriHealth Caritas Florida immediately when they are rendering prenatal care services. All teen pregnant members are considered high-risk and assigned to an AmeriHealth Caritas Florida Bright Start Care Manager.

PCPs are not required to issue a paper referral for in-network specialty services. PCPs must ensure communication with all specialty providers to discuss ongoing and follow-up care. There are some services that require prior authorization, which can be found on www.amerihhealthcaritasfl.com under Provider Resources. Authorization requests for services requiring an authorization can be submitted online at www.navinet.net or via AmeriHealth Caritas Florida 24-Hour Nurse Call Line at **1-855-398-5615**.

For additional information please contact Utilization Management at **1-855-371-8074** or fax **1-855-236-9285**.

AmeriHealth Caritas Florida requires specialists to communicate their findings to the PCP and notify if there is a need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate their members' care, and to make sure the referred specialist is a participating provider with AmeriHealth Caritas Florida.

AmeriHealth Caritas Florida does not use paper referrals. Should a provider desire a standing referral, or access to a specialty care center for a life threatening condition or certain prolonged conditions, the provider must contact the AmeriHealth Caritas Florida Rapid Response and Outreach Team at **855-371-8072** Monday through Friday from 8:00a.m. to 5:00p.m.

Providers are prohibited from making referrals for designated health services to healthcare entities in which the provider or a member of the provider's family has a financial relationship.

Self-Referrals

The following services do not require PCP authorization or referral:

- Prescription drugs, including certain prescribed over-the-counter drugs.
- Emergency services including emergency ambulance transportation.
- OB services, including those of a certified nurse midwife.
- GYN services, including those of a certified nurse midwife.
- Women's health services provided by a Federally Qualified Health Center
- Initial visit for mental health and chemical dependency/substance use disorder services.

- Family planning services and supplies from a qualified Medicaid family planning provider.
- Routine eye care.
- Except for emergency and family planning services, the above services must be obtained through network providers or prior authorized out-of-network providers.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. AmeriHealth Caritas Florida **DOES NOT** guarantee that any provider will receive a set number of members.

If a PCP does declare a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact AmeriHealth Caritas Florida Provider Services at **1-800-617-5727**. A PCP shall not refuse to accept new members as long as the physician has not reached their requested panel size.

Providers shall notify AmeriHealth Caritas Florida at least 45 days in advance of his or her inability to accept additional Medicaid covered persons under AmeriHealth Caritas Florida agreements. AmeriHealth Caritas Florida prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

Provider Termination

Providers should refer to their AmeriHealth Caritas Florida contract for specific information about terminating from AmeriHealth Caritas Florida.

Provider Maintenance: Obligation to Report

Providers should notify AmeriHealth Caritas Florida **in advance** of making any addition or change to your office locations, as referenced in your contract. The standard notification timeframe is at least sixty (60) days prior to making any addition or change to office locations.

MMA Physician Incentive Program (MPIP)

MPIP Covered Physician Types, Included Services and Enhanced Payments. Physicians/ locations qualified to participate in the MMA Physician Incentive Program (MPIP) are in accordance with the qualifications defined by the Agency for Health Care Administration. Qualification is contingent upon the provider's location. During each year of MPIP, plans are required to reassess physician/ location eligibility for the program six months after implementation. This allows providers/ location who become qualified after the implementation date a second opportunity to become eligible for MPIP. Payment to qualified provider/ location for included services will be as defined by the Agency for Health Care Administration. A list of included services can be found at:

https://ahca.myflorida.com/medicaid/statewide_mc/mma_physician_incentive.shtml

Measurement Period. AmeriHealth Caritas Florida will compensate provider/location for MPIP- Covered primary care services as specified by the Agency. The initial duration of the MMA Physician Incentive Program (MPIP) is a (twelve) 12-month period and is measured annually.

PerformPlus® Value Based Incentive Programs

AmeriHealth Caritas Florida offers enhanced incentive programs for high quality and cost-effective care through our PerformPlus® programs. The PerformPlus® programs are designed to improve patient health, reduce unnecessary cost and promote accountable care. Each program contains quality and cost efficiency incentives that align with the National Committee for Quality Assurance (NCQA) standards.

The financial incentives provided in these programs are over and above a practice's base compensation. Value – based incentive payments are based on the performance of the provider's group practice and not on individual performance (unless the participant is a solo practitioner).

Providers interested in joining on of AmeriHealth Caritas Florida's PerformPlus programs may contact their Provider Account Executive or the Provider Services department at **1-800-617-5727**.

Other PCP Responsibilities

- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide culturally competent care.
- Maintain confidentiality of medical information.
- Obtain authorizations for all in-patient and selected outpatient services listed on the current prior authorization list, except for emergency services up to the point of stabilization.
- Provide preventative and chronic care screenings, well care and referrals to community health departments and other agencies in accordance with AHCA provider requirements and public health initiatives.
- Immediately report knowledge of or reasonable suspicion of abuse, neglect or exploitation of a child, aged person or disabled adult, to the Florida Abuse Hotline on the statewide toll free number: **1-800-962-2873**.
- Ensure that staff is mandated to report abuse, neglect and exploitation and has received appropriate training in reporting abuse, neglect and exploitation.
- Participate in any other training as mandated by regulatory authorities and/or AmeriHealth Caritas Florida.
- Follow AmeriHealth Caritas Florida's medical records documentation policy.
- Follow AmeriHealth Caritas Florida's QI and UM program.
- Participate in any other training as mandated by regulatory authorities and/or AmeriHealth Caritas Florida.

AmeriHealth Caritas Florida providers should refer to their contract for complete information regarding their PCP obligations and reimbursement.

Specialist Responsibilities

Selected specialty services require a formal referral from the PCP. The specialist may order diagnostic tests without PCP involvement by following AmeriHealth Caritas Florida's referral guidelines. The specialist must abide by the prior authorization requirements when ordering diagnostic tests. However, the specialist may not refer to other specialists or admit to the hospital without the approval of a PCP, except in a true emergency situation. All non-emergency inpatient admissions require prior authorization from AmeriHealth Caritas Florida.

The specialist provider must:

- Maintain contact with the PCP.
- Obtain referral or authorization from the member's PCP and/or AmeriHealth Caritas Florida's Utilization Management Department as needed before providing services.
- Coordinate the member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five business days of seeing the member.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of medical information.

- Provider shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number **1-800-962-2873**.
- Provider agrees to participate in any other training as mandated by regulatory authorities and/or AmeriHealth Caritas Florida.
- Follow AmeriHealth Caritas Florida's medical documentation policy.
- Follow AmeriHealth Caritas Florida's QI and UM programs.
- For hospice and nursing home providers the bed-hold days will comport with Medicaid fee-for-service applicable policies and procedures.

AmeriHealth Caritas Florida providers should refer to their contract for complete information regarding providers' obligations and mode of reimbursement.

Hospital Responsibilities

AmeriHealth Caritas Florida utilizes a network of hospitals to provide services to AmeriHealth Caritas Florida members.

Hospitals must:

- Cooperate and comply with AmeriHealth Caritas Florida's policies and procedures.
- Notify the PCP immediately or no later than the close of the next business day after the member's appearance in the emergency department.
- Obtain authorizations for all in-patient emergent or urgent admissions through AmeriHealth Caritas Florida's secure, on-line portal within two business days after the date of admission.
- Obtain authorizations for all in-patient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify AmeriHealth Caritas Florida's Utilization Management Department of all maternity admits upon admission and all other admissions by close of the next business day.
- Notify AmeriHealth Caritas Florida's Utilization Management Department of all newborn deliveries on the same day as the delivery.
- Assist AmeriHealth Caritas Florida with identifying members at high-risk for readmission and coordination of discharge planning which includes scheduling, prior to discharge, a post-discharge follow up appointment with the member's PCP or treating specialist.
- Support a consistent effort to effectively communicate to AmeriHealth Caritas Florida the clinical status of members to assist with the discharge planning.
- Provide AmeriHealth Caritas Florida's UM staff access to the hospital's electronic medical record system when applicable.
- Participating hospitals should refer to their contract for complete information regarding the hospital's obligations and reimbursement.
- Provider shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number **1-800-962-2873**.
- Hospital warrants and represents that staff is mandated to report abuse, neglect, and exploitation and has received appropriate training in reporting abuse, neglect and exploitation.
- Provider agrees to participate in any other training as mandated by regulatory authorities and/or AmeriHealth Caritas Florida.

Provider-Initiated Request to Terminate a Member

A AmeriHealth Caritas Florida provider shall not seek or request to terminate his/her relationship with a member, or transfer a member to another provider of care, based upon the member's race, national origin, religion, medical condition, amount or variety of care required, or source of payment, in accordance with F. S. 381.026 (4)(d)(1).

A healthcare provider may terminate a patient relationship at any time; however, the provider may not abandon a patient. Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The provider should have three (3) documented attempts in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider and member relationship.

If a satisfactory relationship cannot be established or maintained due to member non-compliance, abuse, violence, or the threatened violence, the provider shall continue to provide medical care for the AmeriHealth Caritas Florida member until such time that verbal or written notice is received by the member. The Florida Board of Medicine, Florida Medical Association, and American Medical Association's Council on Ethical and Judicial Affairs recommends providers remain available to the patient for at least 30 days to provide emergency services, referrals, prescriptions, and assistance in locating another practitioner for the patient to ensure the continuation of care. (F. S. 381.026) Assistance may include referring the member to AmeriHealth Caritas Florida to locate an in-network provider.

Medical Records

AmeriHealth Caritas Florida providers must keep medical records in a secure location to ensure the member's privacy. All medical records, Medicaid-related member cards, and communications are to be maintained for a period of ten (10) years according to legal, regulatory, and contractual rules of confidentiality and privacy. AmeriHealth Caritas Florida providers must maintain a medical records system that is consistent with professional standards. Providers are to deliver prompt access to records for review, survey or study if needed.

Medical Records Required Information

Medical records should reflect all services and referrals supplied directly by all providers. This includes all ancillary services and diagnostic tests ordered by the provider, and the diagnostic and therapeutic services for which the provider referred the member. Members' medical records must be treated as confidential information and be accessible only to authorized persons.

Medical records must be in accordance with the following standards:

- Include the member's identifying information, including name, member identification number, date of birth, gender, and legal guardianship (if any);
- Include information relating to the member's use of tobacco, alcohol, and drug/substances;
- Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up;
- Reflect the primary language spoken by the member and any translation needs of the member;
- Identify members needing communication assistance in the delivery of health care services;
- Include copies of any completed consent or attestation form(s) used by AmeriHealth Caritas Florida or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13) years;
- Include a copy of the completed screening instrument in the member record and provides a copy to the member;
- Documentation of preterm delivery risk assessment in the member record by week twenty-eight (28) of pregnancy;
- Documentation of nutritional assessment and counseling to all pregnant members and postpartum enrolls and their children (including referrals to the Florida Special Supplemental Nutrition Program for Women, Infants, and Children, Healthy Start and other social services);

- Referral to all members under the age of five (5), and pregnancy, breast feeding, and postpartum members to the local WIC program office using the -Florida WIC Program Medical Referral Form (DH 3075);
- Documentation of referral services in the member record, including reports resulting from the referral;
- Documentation of emergency care encounters in the member record with appropriate medically indicated follow-up; and
- Documentation of the express written and informed consent of the member’s authorized representative (prescriptions for psychotropic medication) i.e., antipsychotics, antidepressants, antianxiety medications, and mood stabilizers) prescribed for a member under the age of thirteen (13) years. In accordance with S.409.912 (16), F.S., AmeriHealth Caritas Florida shall ensure the following requirements are met:
 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. Sample consent/attestation forms that may be used and pharmacies may receive are located at the following link:
https://ahca.myflorida.com/medicaid/Prescribed_Drug/pdf/FL_Consent_Form_Psychotropic_Medications.pdf
 - (a) The completed form must be filed with the prescription (hardcopy or imaged) in the pharmacy and held for audit purposes for a minimum of six (6) years.
 - (b) Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form.
 - (c) Every new prescription will require a new informed consent form.
 - (d) The informed consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescent under the age of eighteen (18) years.

Medical Records Release

Providers are required to adhere to the requirements in safeguarding the confidentiality of member medical records. In addition, ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

A member or authorized representative shall sign and date a release form before any clinical or case records can be released to another party. Clinical/case record release shall occur consistent with state and federal law.

Providers are also required to comply with the privacy and security provisions of HIPAA; and are further required to maintain the confidentiality of a minor’s consultation, examination and treatment for a sexually transmitted disease, in accordance with s. 384.30(2) F.S.

Medical Records Audit

AmeriHealth Caritas Florida conducts record review audits to help ensure adherence with AmeriHealth Caritas Florida’s medical record documentation standards and guidelines, and compliance with state and federal rules, laws and contractual obligations. Included in the records review audits, AmeriHealth Caritas Florida confirms that the records are well documented to facilitate communication, coordination, continuity of care, and promote efficient and effective treatment. Standardized tools along with an established scorecard are utilized to assess compliance with medical record standards and practice guidelines. The audits are conducted as a monitoring activity of provider sites. Additionally, a random sample of newborn and prenatal records are audited annually. Medical records are reviewed to verify they accurately reflect all services provided directly by the provider, including all ancillary services, and all the diagnostic and therapeutic services for which the provider referred the member. Member records will be treated as confidential information and be accessible only to authorized persons.

Advance Directives

AmeriHealth Caritas Florida is committed to ensuring that its members know of, and are able to avail themselves of, their rights to execute advance directives. AmeriHealth Caritas Florida is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and any providers delivering care to AmeriHealth Caritas Florida members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record. All records must contain documentation that the member was provided written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the member has executed an advance directive.

AmeriHealth Caritas Florida recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCPs office should ask if the member has executed an advance directive; the member's response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCPs office and document this request in the member's medical record.
- An advance directive should be included as a part of the member's medical record, including mental health directives.
- If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable.
- Discussion should be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the office should ask the member if they desire more information about advance directives.
- If the member requests further information, member advance directive education/information should be provided (form is available on our website and in the AmeriHealth Caritas Florida Member Welcome Kit).
- Member services representatives will assist members with questions regarding advance directives; however, no employee of AmeriHealth Caritas Florida may serve as witness to an advance directive, or as a member's designated agent or representative.

AmeriHealth Caritas Florida Quality Improvement will monitor compliance with this provision during medical record reviews and as scheduled thereafter.

Cultural Competency: Overview

AmeriHealth Caritas Florida's Cultural Competency program addresses deep-rooted disparities found in today's healthcare industry and recognizes the need to more effectively connect with multicultural patient populations. Our Cultural Competency Program is designed to improve health outcomes among underserved individuals and families in partnership with network providers.

This program utilizes the 15 national Culturally and Linguistically Appropriate Services (CLAS) standards, developed by the U.S. Department of Health and Human Services Office of Minority Health, as the guide and baseline of our standards. These standards fall into the following classifications:

- Principal standard -- provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Governance, leadership and workforce.
- Communication and language assistance.

- Engagement, continuous improvement and accountability.

Cultural Competency: Provider Training

AmeriHealth Caritas Florida provides access to training and evaluation for our network providers to assist in developing culturally competent practices. Our providers are trained in a variety of areas including advancing health equity, improving quality, and helping to eliminate health disparities by providing culturally and linguistically appropriate care.

AmeriHealth Caritas Florida and our providers have access to medical interpreters, signers and TTY services to facilitate communication without cost to the member. We also train our providers on collecting race, ethnicity and language (REL) data to have a better understanding of the CLAS needs of their member panel. Treatment plans need to be respectful of member race, ethnicity, native language, age, gender, and other characteristics that may result in a disparity in decision-making. Written materials need to be respectful of language barriers experienced by our members.

Members of our provider network management team meet with our providers and their staff on a regular basis and provide training in cultural competency on a yearly basis.

Impact of Cultural Competence

Cultural competence is an ongoing process and starts immediately when the member enters the physician office and/or interacts with healthcare delivery in some way. For those taking care of our members, AmeriHealth Caritas Florida is dedicated to assisting our providers and staff to explore their own self-awareness and become much more mindful of cultural and linguistically competent practices. This can avoid:

- Misdiagnosis due to lack of sufficient information.
- Misunderstanding of the treatment plan by the member.
- Non-compliance with the treatment plan due to cultural sensitivity.
- Missed appointments.
- Increased complaints.

Health Disparities

The cost of health disparities can be felt by our members in a variety of ways:

- Lost wages.
- Premature death.
- Barriers to timely care.
- Less likely to receive prenatal care, which may result in babies born with lower birth weight, and increase in infant and maternal mortality rates.
- More frequent utilization of emergency rooms, long wait times, and members leaving without being seen.
- Low-income minority children are less likely to receive childhood immunizations.
- Higher medical costs as a result of non-compliance due to language deficits, cultural differences, and other barriers.

Compliance

AmeriHealth Caritas Florida expects compliance with federal and state requirements, including, but not limited to those set forth in accordance with/by: Medicaid, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, the Office of Inspector General (HHS-OIG) compliance program elements and privacy requirements, including the Health Insurance Portability Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) and the Omnibus Rule. As such, AmeriHealth Caritas Florida has outlined its expectations of staff, subcontractors, vendors, and providers in their ongoing compliance with federal and state

requirements in the AmeriHealth Caritas Florida Compliance Plan. The elements related to provider compliance include Fraud Waste and Abuse, Risk Management, Education and Training.

Fraud, Waste and Abuse (FWA)

AmeriHealth Caritas Florida has a designated Compliance Officer who is primarily responsible for AmeriHealth Caritas Florida Compliance and Special Investigations Unit (SIU) activities, and is qualified to oversee the Fraud and Abuse program to help ensure program integrity. Designed in accordance with applicable state and federal rules and regulations, AmeriHealth Caritas Florida's Anti-Fraud Plan addresses the detection and prevention of potential overpayments, abuse, and fraud related to the provision of, and payment for, Medicaid services. The Anti-Fraud Plan includes FWA policies and procedures designed to help prevent, reduce, detect, investigate, correct, and report known or suspected fraud, waste, and abuse activities, and to implement corrective action. For more information on reporting fraud, waste and abuse visit our website at www.amerihealthcaritasfl.com.

Definitions

Fraud

"Fraud" is an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person (FS 409.913 "Fraud Definition" Section 2 paragraph "C") the term includes any act that constitutes fraud under applicable federal or state law. (Fla. Stat. §409.913(2)(c)(defining fraud)). As applied to the federal health care programs (including the Medicaid program), health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a federal health care program. Some examples of fraud include:

- Billing for services not furnished
- Soliciting, offering or receiving a kickback, bribe or rebate
- Violations of the provider self-referral prohibition

Waste

"Waste," is the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.

Abuse

"Abuse" is defined as provider practices that are inconsistent with generally accepted business or medical practice that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or, as recipient practices that result in unnecessary cost to the Medicaid program (Fla. Stat. §409.913(1)(a)(defining abuse)). In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicaid program. Some examples of abuse include:

- Charging in excess for services or supplies unintentionally
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards

Overpayment

"Overpayment", defined in accordance with Fla. Stat. §409.913(1)(e), includes any amount that is not authorized to be paid by the Medicaid program, whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

False Claims Act

The Florida False Claims Act (the Florida FCA) is a broad-reaching statute defined in Florida Statutes 68.081 through 68.092, designed to address an array of wrongdoing from health care fraud to fraud involving any type of government contract or business relationship involving state or local money. Health care entities that violate the Federal FCA can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 for each false claim submitted to the United States government or its contactors, including state Medicaid agencies. Fla. Stat. §68.082(1)(g) The Federal FCA contains a “qui tam” or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The FCA protects individuals who report under the qui tam provisions from retaliation that results from filing an action under the Act, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

Effective in 2007, the Deficit Reduction Act of 2005 (DRA) increased states’ obligations to fight fraud, waste, and abuse activities within their state Medicaid plans and introduced incentives for the states to enact their own False Claims Acts. Florida has a False Claims Act, codified at Fla.Stat. §68.081, et seq. The purpose of the Florida FCA is to deter persons from knowingly causing or assisting in causing state government to pay claims that are false or fraudulent, and to provide remedies for obtaining treble damages and civil penalties for state government when money is obtained from state government by reason of a false or fraudulent claim. Fla.Stat. §68.081 No proof of intent to defraud is required for liability to attach, but an innocent mistake may be a defense to an action under the Florida FCA. Florida’s FCA includes provisions similar to the federal FCA, allowing for qui tam actions by relators; the Florida Department of Legal Affairs may also bring an action under the Florida FCA. A portion of the amount recovered from prosecuting Medicaid false claims in Florida is deposited to the Medicaid Operating Trust Fund in order to fund rewards for persons who report and provide information relating to Medicaid fraud.

Anti-Kickback Statute

A criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. Fla. Stat. § 456.054

Stark Law

Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. Fla. Stat. § 458.331(1)(i) and 459.015(1)(j)

Provider Responsibilities Related to Fraud, Waste and Abuse

AmeriHealth Caritas Florida’s providers must all comply with the False Claims Act to the extent applicable and assist in the detection and prevention of fraud, waste, and abuse in connection with the provision of services in their provider agreements and the State Contract. Providers are also responsible for including the above-mentioned provisions in their compliance programs.

All suspected or confirmed instances of fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, AmeriHealth Caritas Florida employees/management, providers, subcontractors, vendors, delegated entities, or members under state and/or federal law, must be reported to Medicaid Program Integrity (MPI) within five (5) calendar days of detection. To report suspected Medicaid fraud, contact the MPI hotline at **1-888-419-3456** or complete a complaint form online at <https://apps.ahca.myflorida.com/mp-complaintform/>.

Upon request, and as required by state and/or federal law, providers shall adhere to the following:

Reporting and Preventing Fraud, Waste and Abuse

Compliance with state and federal laws and regulations is mandated. Providers and members may anonymously report suspected fraud, waste, or abuse to the SIU. Please provide as much information as possible or available using one of the following methods:

- Via telephone by calling the Fraud Tip Line at **1-866-833-9718**
- By sending an email to **FraudTip@amerihealthcaritas.com**
- Via postal service
- Online using the Fraud Tip form at <http://home.kmhp.com/index.asp?go=/fraud/>.
- Directly to the state oversight agency:

Medicaid Program Integrity Bureau (MPI), Office of the AHCA Inspector General

Mail:

Kelly Bennett, Chief
2727 Mahan Drive, MS#6
Tallahassee, FL 32308

Email: MPIComplaints@ahca.myflorida.com

Online Form: <https://apps.ahca.myflorida.com/mpicomplaintform/>

Website: <https://ahca.myflorida.com/MCHQ/MPI/>

Hotline: 1-888-419-3456

Phone: (850) 412-4600

Fax: (850) 410-1972

Medicaid Fraud Control Unit of Florida, Office of the Attorney General

Mail:

PL-01 The Capitol
Tallahassee, FL 32399-1050
Hotline: 1-866-966-7226
Phone: 850-414-3990/ 850-414-3300

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program at **1-850-414-3990**. The reward may be up to twenty-five (25) percent of the amount recovered, or a maximum of \$500,000 per case as set forth in Fla. Stat. §409.9203. You can talk to the Attorney General's Office about keeping your identity confidential and protected.

Below are examples of information that will assist AmeriHealth Caritas Florida with an investigation:

- Contact information (i.e., name of individual making the allegation, address, phone number)
- Type of item or service involved in the allegation(s)
- Place of service
- Nature of the allegation(s)
- Timeframe of the allegation(s). As situations warrant, AmeriHealth Caritas Florida may make referrals to appropriate law enforcement and/or the Medical Education Development in Communities (MEDIC)

Risk Management

AmeriHealth Caritas Florida recognizes the importance of minimizing risk to members during the provision of healthcare services. For this reason, AmeriHealth Caritas Florida utilizes a formal risk management program to promote the delivery of optimal and safe healthcare for members. The program allows objective monitoring, evaluation and correction of situations that may occur in the administration and delivery of healthcare services.

Provisions of the Risk Management Program

The Risk Management Program has developed processes in compliance with contractual reporting requirements. The Risk Manager or designee educates providers and subcontractors on adverse and critical incidents, abuse, neglect, exploitation, and human trafficking awareness as well as training regarding incident reporting and timeliness requirements.

All incident reports are reviewed in collaboration with the Quality Improvement Department for potential quality of care, quality of service, adverse incidents, and safety issues. Data collected during the investigative process will be analyzed to identify potential trends. When appropriate, the Risk Management Department will collaborate with providers and subcontractors to determine the best actions for preventing events from reoccurring. Adverse trends will be reviewed internally by the Quality Improvement Committee and Compliance Committee. The Risk Manager will prepare a monthly adverse and critical incident summary report, which includes identified adverse and critical incidents for submission to AHCA.

Suspected abuse, neglect or exploitation of a child and/or vulnerable adult shall be reported immediately online or by phone to the Department of Children and Families Central Abuse Hotline. The Risk Management Department will keep separate confidential electronic files and/or paper records of investigations involving abuse, neglect, and exploitation of AmeriHealth Caritas Florida members.

The provider adverse incident report form can be found on our website at www.amerihealthcaritasfl.com.

Procedures for Adverse Incident Reporting

Providers and subcontractors must report adverse incidents or injuries affecting AmeriHealth Caritas Florida members using the AHCA approved provider adverse incident form. Providers must complete this report immediately upon the incident occurrence, and no later than forty-eight (48) hours of detection or notification. Reporting will include information such as the member's identity, description of the incident, and outcomes including current status of the member. After completion, the form must be submitted to AmeriHealth Caritas Florida Risk Management at **1-305-436-7485** or **acflriskmanagement@amerihealthcaritasfl.com**. The incident report should be maintained in a secure confidential file.

For reporting purposes, Florida defines an injury of an member occurring during delivery of AmeriHealth Caritas Florida's covered services that:

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

Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents. In accordance with our AHCA contract an injury is defined as:

- a. Death.
- b. Brain damage.
- c. Spinal damage.

- d. Permanent disfigurement.
- e. Fracture or dislocation of bones or joints.
- f. Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition.
- g. Any condition requiring surgical intervention to correct or control.
- h. Any condition resulting in the transfer of a patient, within or outside the facility, to a unit providing a more acute level of care.

Examples of reportable events:

- Example A – The performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the AmeriHealth Caritas Florida member's diagnosis or medical condition.
- Example B – A procedure to remove unplanned foreign objects remaining from a surgical procedure.

Provider submission of adverse incident forms from the following providers: health maintenance organizations and healthcare clinics reporting in accordance with s. 641.55, F.S.; ambulatory surgical centers and hospitals reporting in accordance with s. 395.0197, F.S.; assisted living facilities reporting in accordance with s. 429.23, F.S.; nursing facilities reporting in accordance with s. 400.147, F.S.; and crisis stabilization units, residential treatment centers for children and adolescents, and residential treatment facilities reporting in accordance with s. 394.459, F.S. are not contractually required.

Reporting Abuse, Neglect, Exploitation and Human Trafficking

In accordance with AHCA contract, sections 39.201 and 415 of the Florida Statutes, all providers with knowledge or suspicions of abuse, neglect, abandonment, exploitation, or human trafficking of a child or vulnerable adult are required to make a report online or by phone to the Florida Central Abuse Hotline.

Report online at <https://www.myflfamilies.com/service-programs/abuse-hotline/report-online.shtml>

Report by phone: 1-800-962-2873

If you have information regarding suspected human trafficking of an adult anywhere in the United States or of a child **outside of Florida**, please contact the National Human Trafficking Resource Center:

Report by phone: 1-888-373-7888

Report online at <https://humantraffickinghotline.org/>

Definitions

Adult Abuse

Any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions. Fla. Stat. §415.102 (1)

Child Abuse

Any willful act or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child. Fla. Stat. 39.01(2)

Adult Neglect

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. Fla. Stat. 415.102(16)

Child Neglect

Within the context of the definition of “harm,” the term “neglects the child” means that the parent or other person responsible for the child’s welfare fails to supply the child with adequate food, clothing, shelter, or health care, although financially able to do so or although offered financial or other means to do so. However, a parent or legal custodian who, by reason of the legitimate practice of religious beliefs, does not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone, but such an exception does not:

- Eliminate the requirement that such a case be reported to the department;
- Prevent the department from investigating such a case; or
- Preclude a court from ordering, when the health of the child requires it, the provision of medical services by a physician, as defined in this section, or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization. Fla. Stat.39.01(35)(4)(f)

Adult Exploitation

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. Fla. Stat. 415.102 (8)(a).

Human Trafficking

Under both federal and Florida law, it is defined as the transporting, soliciting, recruiting, harboring, providing, or obtaining of another person for transport; for the purposes of forced labor, domestic servitude or sexual exploitation using force, fraud and/or coercion. Fla. Stat. 787.06 (7)(d).

Identifying victims of human trafficking

The Office on Trafficking in Persons, Administration for Children and Families, and U.S. Department of Health and Human Services are committed to preventing human trafficking. Healthcare providers may come into contact with victims of human trafficking and have a unique opportunity to connect them with much needed support and services. Anyone in a medical position including clerical staff, lab technicians, nursing staff, security personnel, case managers, and physicians may be in a position to identify human trafficking.

The National Human Trafficking Resource Center provides the following list of potential red flags and indicators. Patients who are potential victims of human trafficking may exhibit the behaviors listed below. Please note that this list is not exhaustive. Each indicator taken individually may not imply a trafficking situation and not all victims of human trafficking will exhibit these signs. However, the recognition of several indicators may point to the need for referrals and further assessment.

General indicators of human trafficking:

- Shares a scripted or inconsistent history.
- Is unwilling or hesitant to answer questions about the injury or illness.

- Is accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them.
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer).
- Demonstrates fearful or nervous behavior or avoids eye contact.
- Is resistant to assistance or demonstrates hostile behavior.
- Is unable to provide his/her address.
- Is not aware of his/her location, the current date, or time.
- Is not in possession of his/her identification documents.
- Is not in control of his or her own money.
- Is not being paid or wages are withheld.

Labor trafficking indicators:

- Has been abused at work or threatened with harm by an employer or supervisor.
- Is not allowed to take adequate breaks, food, or water while at work.
- Is not provided with adequate personal protective equipment for hazardous work.
- Was recruited for different work than he/she is currently doing.
- Is required to live in housing provided by employer.
- Has a debt to employer or recruiter that he/she cannot pay off.

Sex trafficking indicators:

- Patient is under the age of 18 and is involved in the commercial sex industry.
- Has tattoos or other forms of branding, such as tattoos that say, "Daddy," "Property of..." "For sale," etc.
- Reports an unusually high numbers of sexual partners.
- Does not have appropriate clothing for the weather or venue.
- Uses language common in the commercial sex industry.

Physical health indicators:

- Signs of physical abuse or unexplained injuries
 - Bruising
 - Burns
 - Cuts or wounds
 - Blunt force trauma
 - Fractures
 - Broken teeth
 - Signs of torture
- Neurological conditions
 - Traumatic brain injury
 - Headaches or migraines
 - Unexplained memory loss
 - Vertigo of unknown etiology
 - Insomnia
 - Difficulty concentrating
- Cardiovascular/respiratory conditions that appear to be caused or worsened by stress, such as:
 - Arrhythmia
 - High blood pressure

- Acute Respiratory Distress
- Gastrointestinal conditions that appear to be caused or worsened by stress, such as:
 - Constipation
 - Irritable bowel syndrome
- Dietary health issues
 - Severe weight loss
 - Malnutrition
 - Loss of appetite
- Reproductive issues
 - Sexually transmitted infections
 - Genitourinary issues
 - Repeated unwanted pregnancies
 - Forced or pressured abortions
 - Genital trauma
 - Sexual dysfunction
 - Retained foreign body
- Substance use disorders
- Other health issues
 - Effects of prolonged exposure to extreme temperatures
 - Effects of prolonged exposure to industrial or agricultural chemicals
 - Somatic complaints

Mental health indicators:

- Depression
- Suicidal ideation
- Self-harming behaviors
- Anxiety
- Post-traumatic stress disorder
- Nightmares
- Flashbacks
- Lack of emotional responsiveness
- Feelings of shame or guilt
- Hyper-vigilance
- Hostility
- Attachment disorders
 - Lack of or difficulty in engaging in social interactions
 - Signs of withdrawal, fear, sadness, or irritability
- Depersonalization or derealization
 - Feeling like an outside observer of themselves, as if watching themselves in a movie
 - Emotional or physical numbness of senses
 - Feeling alienated from or unfamiliar with their surroundings
 - Distortions in perception of time
- Dissociation disorders
 - Memory loss
 - A sense of being detached from themselves

- A lack of a sense of self-identity, or switching between alternate identities
- A perception of the people and things around them as distorted or unreal

Social or developmental indicators:

- Increased engagement in high risk behaviors, such as running away or early sexual initiation if a minor
- Trauma bonding with trafficker or other victims (e.g. Stockholm syndrome)
- Difficulty establishing or maintaining healthy relationships
- Delayed physical or cognitive development
- Impaired social skills

The information provided above may be located on the National Human Trafficking Resource Center website at www.traffickingresourcecenter.org. For additional resources, please contact the National Human Trafficking Resource Center at **1-888-373-7888** or email at nhtrc@polarisproject.org.

Compliance Education and Training

AmeriHealth Caritas Florida provides compliance-related trainings to new and existing participating providers. Compliance training covers the following topics:

- Ethics and legal compliance issues
- Fraud, waste, abuse, and overpayments
- Health Insurance Portability Accountability Act (HIPAA)
- Risk Management

At least annually, AmeriHealth Caritas Florida will conduct a live webinar for providers including the topics listed above. Information about training and educational opportunities can be found on the AmeriHealth Caritas Florida website at www.amerhealthcaritasfl.com.

Chapter 8: Member Rights and Responsibilities

In accordance with 42 CFR 438.100, Florida law requires that healthcare providers and facilities recognize member rights. Providers must post a copy of the summary of Florida's Patient's Bill of Rights and Responsibilities. Members have the right to request and receive from their health care provider, a complete copy of the Florida Patient's Bill of Rights and Responsibilities.

Patient's Bill of Rights and Responsibilities

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well-being of patients and to promote better communication between the patient and the healthcare provider. Florida law requires that a patient's healthcare provider or health care facility recognize those rights while the patient is receiving medical care and that the patient respect the healthcare provider's or healthcare facility's right to expect certain behavior on the part of patients. Patients may request a copy of the full text of this law from their healthcare provider or health care facility. A summary of patients' rights and responsibilities are as follows. A patient has the right to:

- Be treated with courtesy and respect
- Have their dignity and privacy considered and respected at all times
- Receive a quick and useful response to questions and requests
- Know who is providing medical services and who is responsible for their care
- Know what member services are available, including whether an interpreter is available if they do not speak English
- Know what rules and laws apply to their conduct
- Be given easy to follow information about your diagnosis, the treatment they need, choices of treatments and alternatives, risks, and how these treatments will help them
- Make choices about their health care and say no any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for their healthcare
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost them
- Get a copy of a bill and have the charges explained to them
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if they do not get treatment
- Know if medical treatment is for experimental research and be able to say yes or no to participating in such research
- Make a complaint when their rights are not respected
- Ask for another doctor when they do not agree with their doctor (second medical opinion)
- Get a copy of their medical record and ask to have information added or corrected in their record, if needed
- Have their medical records kept private and shared only when required by law or with their approval
- Decide how they want medical decisions made if they can't make them by themselves (advanced directive)
- To file a grievance about any matter other than a Plan's decision about their services.
- To appeal a Plan's decision about their services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for them that is part of our Plan
- Speak freely about their health care and concerns without any bad results
- Freely exercise their rights without the Plan or its network providers treating them badly
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Request and receive a copy of their medical records and ask that they be amended or corrected

A patient is responsible to:

- Give accurate information about their health to their Plan and providers
- Tell their provider about unexpected changes in their health condition
- Talk to their provider to make sure they understand a course of action and what is expected of them
- Listen to their provider, follow instructions and ask questions
- Keep their appointments or notify their provider if they will not be able to keep an appointment
- Be responsible for their actions if treatment is refused or if they do not follow the health care provider's instructions
- Make sure payment is made for non-covered services they receive
- Follow health care facility conduct rules and regulations
- Treat health care staff with respect
- Tell us if they have problems with any healthcare staff
- Use the emergency room only for real emergencies
- Notify their case manager if they have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for their safety
- Report fraud, abuse and overpayment

Chapter 9: Pharmacy

Pharmaceutical management is a critical component of AmeriHealth Caritas Florida's success. Prescription services are one of the largest service and expenditure areas under the Florida Medicaid program. The Plan's goal is to manage pharmacy costs while effectively maintaining optimal health outcomes for our members.

The pharmacy benefit is administered by the Pharmacy Benefit Manager (PBM). There are certain medications on the AHCA Preferred Drug List that require prior authorization. Various clinical edits including Prior Authorization and Age Limits are included on the posted formulary for specific medications.

Prior authorization forms and criteria can be accessed from our website at www.amerhealthcaritasfl.com. It is important to remember that plans may be less stringent than the posted criteria for certain medications or classes. As part of the prior authorization process, providers must complete a Prior Authorization Request form. The form must be 100% completed and submitted along with all appropriate documentation (medical history, previous therapies tried, additional rationale, etc.) which may help us process the request. Incomplete forms or missing documentation may delay or prevent a request from being processed. The current prior authorization forms may be downloaded by visiting www.amerhealthcaritasfl.com.

PerformRxSM provides pharmacy benefit management services to AmeriHealth Caritas Florida.

- **You may fax prior authorization requests to PerformRx at 1-855-825-2717.**
- **You may call Provider Services at 1-800-617-5727 for assistance.**

For pharmacy questions, call the AmeriHealth Caritas Florida Pharmacy Department at **1-855-371-3963**, available 24 hours a day, seven days a week.

Upon approval of a specialty authorization, you can forward the corresponding prescription to PerformSpecialty[®] via fax at **1-844-489-9565** for prompt service. You can contact them by phone at **1-855-287-7888**.

AHCA Preferred Drug List (PDL)

AmeriHealth Caritas Florida has adopted the AHCA PDL and provides all prescription drugs and dosage forms in congruence with the Agency's direction. The PDL is a clinical reference of medications that are selected by the AHCA Pharmacy and Therapeutics Committee (P&T Committee). We encourage our providers to prescribe generic medications when the generic is preferred by AHCA and to adhere to the PDL.

A comprehensive list of AmeriHealth Caritas Florida's formulary can be accessed at this link on our website: <https://www.amerhealthcaritasfl.com/provider/resources/pharmacy-services.aspx>. The formulary may be accessed and reviewed by clicking on the "Preferred Drug List (formulary)" link. This link will direct the user to the searchable PDL on AHCA's website. This searchable version will provide details regarding age limits, prior authorization and other coverage requirements. There is also a link labeled "Summary of drug limitations" which provides all quantity limits and age limits for applicable drugs.

When a non-PDL (non-preferred) agent or an agent that has an associated edit is inadvertently prescribed, prescribers and pharmacists are encouraged to work together to convert to a preferred formulary agent when appropriate.

Formulary Changes

The AHCA Preferred Drug List and Changes Summary Report, which lists changes made to the preferred drug list as a result of the last AHCA Pharmaceutical and Therapeutics Committee meeting, may be accessed from the same AmeriHealth Caritas Florida web page referenced above or on AHCA's website at

https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml.

In the event that there is a formulary change, various types of communications may be utilized depending on the type of change. Communication strategies may include letters, fax blasts, web documents, provider alerts, etc. Any necessary communication will be completed as early as possible, prior to the implementation of a change. Most direct communications will be the result of a negative formulary change such as removal of a medication from the formulary or the addition of a clinical edit.

Coverage Limitations

AmeriHealth Caritas Florida covers the medication categories that are listed on the PDL. Excluded items are as follows:

- Anti-hemophilia products;
 - Factor products are distributed through the Comprehensive Hemophilia Disease Management Program
- Cough and cold medications for members age twenty-one (21) and over;
- Drug Efficacy Study Implementation (DESI) ineffective drugs as designated by AHCA;
- Drugs used to treat infertility;
- Experimental/Investigational pharmaceuticals or products;
- Erectile dysfunction products prescribed to treat impotence;
- Hair growth restorers and other drugs used for cosmetic purposes;
- Prostheses, appliances and devices (except products for diabetes and products used for contraception);
- Nutritional supplements;
- Oral vitamins and minerals (except those listed in the PDL);
- Over-the-counter (OTC) drugs (except those listed in the PDL); and
- Weight loss/gain medications.

Additionally, AmeriHealth Caritas Florida does not reimburse for early prescription refills, duplicate therapy, or medication dosages that exceed the Food and Drug Administration maximum dose under the Agency's direction.

Carve-Out Medications

A portion of the pharmacy benefit for Medicaid beneficiaries is "carved-out" by the State of Florida. Hemophilia drugs are an excluded service from the health plans benefit package. They are covered through the fee-for-service Statewide Medicaid Comprehensive Hemophilia Disease Management Program. Though not a covered benefit through the Statewide Medicaid Managed Care Program, health plans are required to coordinate the care of their members who require services covered outside of the managed care delivery system.

CVS Caremark is responsible for the Statewide Medicaid Comprehensive Hemophilia Management Program. CVS Caremark's contract, combines the provision of pharmaceutical products, pharmaceutical management, and disease management (e.g., 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.

CVS Caremark can be reached Monday- Friday at **1-888-826-5621**, option 4 for claims questions associated with hemophilia medications. You can also find additional information on the Agency for Healthcare Administration's website at https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/fee-for-service/hemophilia.shtml .

Generic Substitution

AmeriHealth Caritas Florida requires that brand medications be substituted for generic medications when an equivalent generic is available and when the formulary allows for coverage of the generic. There are some medications for which the brand medication is preferred by AHCA.

Informed Consent for Psychotropic Medications

AmeriHealth Caritas Florida requires that prescriptions for psychotropic medications prescribed for a member under the age of thirteen (13) be accompanied by the express written and informed consent of the member's parent or legal guardian. Psychotropic (psychotherapeutic) medications include antipsychotics, antidepressants, antianxiety medications, and mood stabilizers. Anticonvulsants and attention-deficit/hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included at this time.

The prescriber must document the consent in the child's medical record and provide the pharmacy with a signed attestation of the consent with the prescription. The prescriber must ensure completion of an appropriate attestation form.

The completed form must be filed with the prescription (hardcopy or scanned) in the pharmacy and held for audit purposes for a minimum of six (6) years. Pharmacies may not add refills to old prescriptions to circumvent the need for an updated informed consent form. Every new prescription for psychotropic medications will require a new consent form. The consent forms do not replace prior authorization requirements for non-PDL medications or prior authorized antipsychotics for children and adolescents under the age of eighteen (18) years.

For consent forms and resources visit https://ahca.myflorida.com/Medicaid/Prescribed_Drug/med_resource.shtml.

Injectables

AmeriHealth Caritas Florida covers limited self-administered, injectable medications (e.g. Epinephrine). For a complete list, please reference the [Preferred Drug List](#) (PDL). Most other injectable medications will require prior authorization.

Over-the-Counter (OTC) Medications

AmeriHealth Caritas Florida covers several OTC products. Our members receive an OTC benefit of \$25 per household per month. For more information and a list of available OTC products, visit our website at www.amerhealthcaritasfl.com.

Specialty Medications

Several specialty and injectable medications are listed on the PDL. Additionally, AmeriHealth Caritas Florida also adheres to the AHCA medication criteria for specialty, injectable and other medications requiring prior authorization. The majority of the specialty and injectable medications listed on the PDL will require a prior authorization. Please call the AmeriHealth Caritas Florida Pharmacy Department at **1-855-371-3963** to obtain more detailed information about these medications.

Working with our Specialty Pharmacy Provider

AmeriHealth Caritas Florida utilizes an exclusive specialty pharmacy, PerformSpecialty to fill most specialty and some injectable medications. Most of these medications require a prior authorization. Please call PerformSpecialty at **1-855-287-7888** or fax the prescription request or prior authorization form to **1-844-489-9565**.

Once approved PerformSpecialty will call the member for delivery confirmation. If you prefer the medication be delivered to your office instead please note that in your request. More information can be found at www.performspecialty.com.

Pharmacy Prior Authorization

Providers are responsible for obtaining prior authorization. A prior authorization is a requirement for physicians to approve medication requests from the health insurance plan. Providers may not bill members for services that require prior authorization for which authorization was not obtained. Authorization is not a guarantee of payment. Other limitations or requirements may apply.

Please refer to the links below for the most up-to-date Preferred Drug List (PDL). The links define the AHCA preferred medications and those requiring prior authorization.

For the PDL visit https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

For prior authorization criteria visit https://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria.shtml

1. Submit authorization requests to the PerformRxSM Prior Authorization team by fax at 1-855-825-2717.

Mailing Address:

PerformRx
PO Box 516
Essington, PA 19029

For any questions, call AmeriHealth Caritas Florida Pharmacy Department at **1-855-371-3963**.

2. To submit requests for medication with Healthcare Common Procedure Coding System (HCPCS) codes that require authorization, include the HCPCS code that corresponds to the medication in the request. If the HCPCS code is a miscellaneous code, the National Drug Code (NDC) number must also be included on the request.

Please refer to the AmeriHealth Caritas Florida website at www.amerhealthcaritasfl.com for the most current information.

Chapter 10: Quality Improvement Program

Overview

The AmeriHealth Caritas Florida Quality Improvement (QI) Program provides a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided the AmeriHealth Caritas Florida members.

The AmeriHealth Caritas Florida model of care centers on the individual member with a direct connection to a primary care provider. Primary care providers are defined as individual practitioners who provide primary care services and manage routine healthcare needs. A Primary Care Provider is a participating provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an a member. Primary care physician relationships are critical to sustained, comprehensive, and coordinated medical care.

Organizational Structure, Governing Bodies, and Committee Structure

The AmeriHealth Caritas Florida Board of Directors (Board) has ultimate authority and accountability for the oversight of the quality of care and services provided to our members. The Board oversees and supports the Quality Improvement program and provides strategic guidance.

Operational responsibility for the development, implementation, monitoring and evaluation of the QI program is delegated by the Board to AmeriHealth Caritas Florida’s market president and Quality Improvement Committee. The AmeriHealth Caritas Florida leadership group meets with the Board on a monthly basis. Information is then shared to the directors of various departments.

Every year, the Director of Quality Management engages directly with the Board of Directors for a quality summit. The Quality Improvement Committee (QIC) is managed through the Quality department with oversight by the Director of Quality Management with the Chief Medical Officer serving as the Chair.

The committee structure is comprised of the Quality Improvement Committee, which has three sub-committees including the Peer Review Committee, the Quality of Service Committee, and the Credentialing Committee. The Quality of Service Committee has a sub-committee the Cultural Competency and Service Quality Subcommittee.

Goals and Objectives of the Quality Improvement Program

AmeriHealth Caritas Florida’s Quality Improvement Program facilitates the following:

- The effective collection, analysis and reporting of data for a variety of programs.
- The management and reporting of process improvement plans mandated by AHCA.
- Addressing the clinical, psychosocial and function needs of health plan members.
- Reviewing utilization trends including over/under utilization.
- Establishing performance targets for both member and provider satisfaction.
- Works to minimize fragmentation and/or duplication of services through the integration of quality improvement activities across functional areas.
- Maintains compliance with preventive and clinical practice guideline.
- Maintains compliance with all applicable regulatory requirements and accreditation standards.
- Monitors member quality of care and access to care.
- Reducing healthcare disparities by collecting race, ethnicity and language data to monitor and ensure the delivery of culturally competent healthcare.

- Reporting of and incorporation of social determinants of care outcomes, assist in planning for interventions to improve quality of life for our members.
- Establishing and maintaining all continuous quality improvement functionality at AmeriHealth Caritas Florida.
- Reviewing quality of care and health outcomes.
- Providing clinical and service improvement initiatives and recommendations for our members/populations.
- Provides oversight of delegation and credentialing-re-credentialing processes.
- Maintaining a system for measuring performance across the organization and networks.
- Working with members, providers and community resources to improve quality of care.
- Utilizing the provider outreach team to provide quality improvement information to network providers.
- Conducting quality of care reviews relative to patient safety.
- Monitoring and ensuring the delivery of culturally competent healthcare.
- Monitoring complaints and grievances.
- Monitoring and reporting on preventive care rendered to our members.

Health Effectiveness Data and Information Set (HEDIS)

HEDIS is a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance. Health plans are measured in the following areas:

- Effectiveness of care.
- Access/availability of care.
- Experience of care.
- Utilization and relative resource use.

HEDIS was developed by the National Committee for Quality Assurance (NCQA). HEDIS reporting is required under our AHCA contract and consists of six major measure groupings:

- 1) Well-child visits
- 2) Other preventative
- 3) Prenatal/perinatal care
- 4) Comprehensive diabetes care
- 5) Other chronic and acute care
- 6) Mental health and substance use

HEDIS rates are calculated based on two types of data: administrative data and hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member records to abstract data for services rendered but not reported through claims/encounter data. This typically happens sometime between March and May each year.

Improving HEDIS scores depends on accurate documentation and billing for each claim/encounter for services rendered to members. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will reduce the number of medical record reviews that need to be done in the hybrid season.

Quality Enhancements

AmeriHealth Caritas Florida connects members to health-related, community-based services for children's programs, domestic violence prevention programs, pregnancy prevention programs, prenatal/postpartum pregnancy programs,

and behavioral health programs. A complete list and additional details on these quality enhancements is available online at www.amerhealthcaritasfl.com.

The following services are available to our members and may be accessed by providers:

- AmeriHealth Caritas Florida offers Quality Enhancements (QE) in community settings and as components of established programs. AmeriHealth Caritas Florida will make a good faith effort to work with the following agencies and community organizations to coordinate access to already established QE services:
 1. Healthy Start coalitions
 2. County health departments
 3. Early intervention programs
 4. Local domestic violence agencies
 5. United Way
 6. Community hospitals
 7. Federally Qualified Health Centers
- QE referrals (made by Population Health Management case managers/care connectors or other staff such as member service staff) and follow-up related to the services received are documented in AmeriHealth Caritas Florida's Medical Management system. Providers are notified through the provider handbook that QE referrals and follow up on the members' receipt of services must be documented in members' medical records.
- AmeriHealth Caritas Florida offers the following QEs:
 1. Community based educational sessions for the mothers of infants and children addressing self-care for common childhood illnesses. Alternatively, AmeriHealth Caritas Florida may involve or refer members in existing community children's programs.
 2. Health Fairs – The Health Plan participates in local community health fairs to promote general wellness programs, prevention and early-intervention services for children
 3. Provider Education Offerings – Provider education programs to promote proper nutrition, breast-feeding, immunizations, well-child visits, wellness, prevention, early intervention services, domestic violence screening.
 4. Domestic Violence – In addition to the provider education offerings mentioned above, AmeriHealth Caritas Florida's care managers/care connectors educate female members on available community resources and support for victims of domestic violence. In addition, members receive information regarding domestic violence in the member handbook and member web site.
 5. Pregnancy Prevention – AmeriHealth Caritas Florida partners with the Abstinence Education Program to promote program attendance to members. Alternatively, AmeriHealth Caritas Florida may involve members in existing community pregnancy prevention programs.
 6. Prenatal and post-partum pregnancy programs – AmeriHealth Caritas Florida care managers/care connectors will utilize local community based services to support a woman and her baby during her pregnancy and the post-partum period. AmeriHealth Caritas Florida shall provide regular home visits, conducted by a home health nurse or aide, and counseling and educational materials to pregnant and postpartum members who are not in compliance with AmeriHealth Caritas Florida's prenatal and postpartum programs. Our New Mom and Baby Program provides home visits to post-partum members, conducted by a community health navigator. During the visit, the community health navigator obtains pertinent information relating to the pregnancy such as delivery date and post-partum medical appointments and provides educational materials and care gap counseling.

7. Behavioral Health Programs – AmeriHealth Caritas Florida has various departments that identify the need for a member referral to our behavioral health provider. A behavioral health intake coordinator receives each referral and assigns it to a care coordinator/manager.

AmeriHealth Caritas Florida provides information regarding the availability of these services to members through documentation in the Member Handbook, on AmeriHealth Caritas Florida’s website at www.amerhealthcaritasfl.com, and through the provision of educational materials. Members also have access to this information by calling AmeriHealth Caritas Florida Member Services at **1-855-355-9800**, where a Member Service Representative will be available to provide the information and answer any questions the member may have. AmeriHealth Caritas Florida offers substance use screening training to all of its providers on an annual basis.

Chapter 11: Healthy Behaviors

AmeriHealth Caritas Florida takes a proactive role in engaging members to make healthy decisions and positive lifestyle changes. Members who participate in our Healthy Behaviors Program earn gift cards for up to \$50 when they complete any of the following:

- Smoking Cessation Care Management Program
- Weight Loss Care Management Program
- Alcohol or Substance Use Care Management Program
- Behavioral Health Follow Up Visits
- Diabetes Screening
- Diabetes Eye Exams
- Maternity Visits
- Postpartum Visits
- Well-Child Programs
- Child and Adolescent Well-Care visits
- Adult Access to Preventive or Ambulatory Care Visit
- Lead Screening
- Breast Cancer Screening
- Cervical Cancer Screening

These programs are offered at no cost to members. If you have AmeriHealth Caritas Florida patients who could benefit from participating in a Healthy Behaviors Program, please instruct the AmeriHealth Caritas Florida member to call Member Services at **1-855-355-9800 (TTY 1-855-358-5856)**.

Chapter 12: Telehealth Solutions

AmeriHealth Caritas Florida readily embraces telehealth to better engage members in their care and improve outcomes. AmeriHealth Caritas Florida can even assist members with technology barriers. AmeriHealth Caritas Florida offers a **smartphone at no cost** (one per household for members 18 and over). The member can call **1-877-631-2550** and use the promo code **AMERIHEALTH** to register.

If your practice meets the current telehealth requirements indicated, please obtain a copy of the Telehealth Attestation form from our website so that we can inform members of your telehealth service option. The completed form can be returned to **PNM_Inquiries@amerihealthcaritasfl.com**.

Requirements

Telehealth is the practice of health care delivery by a practitioner who is located at a site other than the site where the member is located for the purposes of evaluation, diagnosis, or treatment, as defined by Agency for Health Care Administration (AHCA) guidelines.

The following provisions apply to the use of telehealth services:

1. Telehealth must be provided by practitioners licensed within their scope of practice to perform the service;
2. Telehealth services must use interactive telecommunications equipment that minimally includes real time, two-way interactive communication between a member and a practitioner using audio and video equipment;
3. Telecommunications equipment and telehealth operations must comply with technical safeguards in 45 CFR 164.312, where applicable;
4. Providers must comply with HIPPA regulations related to telehealth communications.
5. Providers must include the modifier GT on the CMS-1500 claim form to indicate a telehealth service.

AmeriHealth Caritas Florida follows AHCA guidelines. Please continue to follow AHCA's requirements on telehealth.

Documentation

When treating AmeriHealth Caritas Florida members, please include the following items in your documentation for telehealth services:

1. Documentation regarding the use of telehealth must be included in the medical record or progress notes for each encounter;
2. Documentation of equipment used for the covered, eligible telehealth services provided; and
3. A signed statement from the patient or his/her authorized representative indicating their choice to receive telehealth services. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided.

To obtain a copy of the [Telehealth Attestation](#) or find [more information on telehealth](#), please visit www.amerihealthcaritasfl.com.

Chapter 13: Behavioral Health

As of January 1, 2021, the management of behavioral health and substance use benefits has transitioned to AmeriHealth Caritas Florida. The management of the behavioral health services in-house allows us to more fully integrate medical care with behavioral health care, creating a more holistic approach.

Integrating Behavioral and Physical Health Care

AmeriHealth Caritas Florida members are treated with a holistic approach, integrating care to address their physical and behavioral health needs. We work with the appropriate primary care provider and behavioral health providers to develop an integrated treatment plan. We understand that the coordination of care for these members experiencing comorbid conditions is imperative. Care managers will facilitate communication between physical and behavioral health providers routinely and, with appropriate consent. For care coordination assistance, behavioral health providers may contact the AmeriHealth Caritas Florida Rapid Response and Outreach Team at **1-855-371-8072**.

Members seeking behavioral health services. AmeriHealth Caritas Florida helps members identify what services would be helpful, and then finds the right provider to help meet their needs. Participating providers, along with their specialties, can be found on our online provider directory at www.amerihealthcaritasfl.com. AmeriHealth Caritas Florida members do not need a referral from their PCP for any behavioral health service. For emergency behavioral health services, contact 911 or have the member go to the nearest emergency room.

Covered services. AmeriHealth Caritas Florida members have access to a full range of medically necessary behavioral health services from outpatient to acute inpatient treatment for mental health and substance use issues. The Medical Necessity Criteria (MNC) and prior authorization information for behavioral health services are available on our website at www.amerihealthcaritasfl.com.

Claims and billing. Behavioral health providers will follow the same billing procedures as medical health care providers. Please refer to the Claims and Billing section of this manual or this information is also available on our website. Please contact Provider Services at **1-800-617-5727** with any questions.

Screening, Brief Intervention and Referral to Treatment (SBIRT). We are working diligently to address alcohol and drug use through early identification and prevention. As a network provider, you play an important role in identifying at-risk members. We support a program called *SBIRT: Raise the Topic*, for early substance use disorder screening, brief intervention and referral to treatment (SBIRT) using an evidence-based approach that is widely recommended. We have developed a robust program to support your staff with the tools and resources essential to integrating SBIRT into your practice. The training includes live and webinar options to meet your needs, and ongoing support to insure your success. If you would like to learn more, contact your AmeriHealth Caritas Florida Provider Network Management Account Executive, or call Provider Services at **1-800-617-5727**.

Chapter 14: Provider Assistance with Public Health Services

AmeriHealth Caritas Florida is required to coordinate with public health entities regarding the provision of public health services. Providers must assist AmeriHealth Caritas Florida in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases, which are preventable by immunization as defined by state law.
- Assisting in the notification or referral of any communicable disease outbreaks involving members to the local public health entity, as defined by state law.
- Referring to the local public health entity for tuberculosis contact investigation, evaluation and the preventive treatment of persons with whom the member has come into contact.
- Referring members to the local public health entity for STD/HIV contact investigation, evaluation and preventive treatment of persons whom the member has come into contact.
- Providing all women of childbearing age HIV counseling and offer them HIV testing at the initial prenatal care visit, and again at 28 to 32 weeks. All women who are infected with HIV are counseled about and offered the latest antiretroviral regimen.
- Screening all pregnant members for the Hepatitis B surface antigen and ensure that infants born to HBsAg-positive members receive Hepatitis B Immune Globulin and Hepatitis B vaccine once they are stable and ongoing testing for HBsAg.
- Referring members for WIC services and information sharing as appropriate.
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Identifying and reporting to applicable authorities any suspected abuse or neglect.
- Assisting in the collection and verification of race/ethnicity and primary language data.

Chapter 15: Marketing Activities

AmeriHealth Caritas Florida maintains compliance with all Agency guidelines regarding marketing activities. As such, providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade potential members to enroll in AmeriHealth Caritas Florida based on financial or any other interests of the provider.
- Mail marketing materials on behalf of AmeriHealth Caritas Florida.
- Offer anything of value to persuade potential members to select them as their provider or to enroll in AmeriHealth Caritas Florida.
- Accept compensation directly or indirectly from AmeriHealth Caritas Florida for marketing activities.

Appendix A: AmeriHealth Caritas Florida Department Contact Information

| Department | Phone Number | Fax Number |
|------------------------------------|---------------------------------------|---|
| 24-Hour Nurse Call Line | 1-855-398-5615 | |
| Bright Start® Maternity Program | 1-855-371-8076 | 1-855-358-5852 |
| Claim Status | 1-800-617-5727 | |
| Fraud, Waste & Abuse | 1-866-833-9718 | |
| Healthy Behaviors Program | 1-855-236-9281 | |
| Integrated Health Care Management | 1-855-371-8072 | 1-855-358-5851 |
| Member Complaints | 1-855-355-9800 | |
| Member Grievances & Appeals | 1-855-371-8078 | 1-855-358-5847 |
| Member Services | 1-855-355-9800 TTY: 1-855-358-5856 | |
| Member Services, Behavioral Health | 1-855-371-3967 | |
| Provider Complaints | 1-800-617-5727 | 1-855-358-5853 |
| Provider Services | 1-800-617-5727 | 1-855-358-5849 |
| Quality Improvement | | 1-855-358-5854 |
| Rapid Response & Outreach | 1-855-371-8072 | 1-855-236-9281 |
| Utilization Management | 1-855-371-8074 | Inpatient 1-855-236-9293 Prior Authorization 1-855-236-9285 |

Appendix B: Subcontractor and Vendor Contact Information

| Services | Name | Phone Number |
|--------------------------------------|--|----------------|
| Audiology | HearUSA Distribution LLC | 1-800-731-3277 |
| Electronic Claims Submission | Change Healthcare Solutions LLC | 1-877-363-3666 |
| Home Health Services | Coastal Care Services | 1-855-481-0505 |
| Laboratory | Quest Diagnostics | 1-866-697-8378 |
| Non-Emergency Medical Transportation | MTM | 1-855-371-3968 |
| Optometry and Ophthalmology | Premier Eye Care of Florida | 1-855-371-3961 |
| Orthotics and Prosthetics | Hanger Prosthetics and Orthotics, Inc. | 1-877-754-6542 |
| Payment Integrity | Optum Insight | 1-800-304-5649 |
| Pharmacy | PerformRx | 1-855-371-3963 |

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