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A new concept in Managed Healthcare
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INTRODUCTION

CarePlus Health Plans, Inc., (“CarePlus”) is a Florida-based health maintenance organization (HMO) with a Medicare Advantage-Prescription Drug (MAPD) contract committed to serving our members, our community, and our providers through:

- TEAMWORK
- QUALITY OF CARE
- COMMUNITY SERVICES
- PROVIDER SATISFACTION

**Purpose of this manual:** CarePlus’ Facility Manual furnishes providers and their staff with the policies, procedures and guidelines used to administer CarePlus’ healthcare benefits/services. This manual replaces and supersedes the previous version dated February 2019. In accordance with the **Compliance with Plan Rules** clause of the provider agreement, it is important that all contracted providers and administrators review this manual and abide by all provisions contained herein, as applicable. Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this manual shall be incorporated herein by this reference and shall apply to providers and/or CarePlus where applicable. Such laws and regulations, if more stringent, take precedence over the content in this manual. Providers are responsible for complying with all laws and regulations that are applicable. The CarePlus Facility Manual is updated annually and a copy of the most up-to-date manual is always available on the CarePlus website at [https://www.careplushealthplans.com/careplus-providers/forms](https://www.careplushealthplans.com/careplus-providers/forms). A paper copy may be obtained at any time upon request to CarePlus.

**Responsibility for Provision of Medical Services:** Providers make all independent healthcare treatment decisions. Additionally, providers are responsible for the costs, damages, claims, and liabilities that result from their own actions. CarePlus does not endorse or control the clinical judgment or treatment recommendations made by providers.

**CarePlus Service Areas:** Brevard, Broward, Clay, Duval, Hillsborough, Indian River, Lake, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Seminole, Sumter, and Volusia counties.

**Provider Operations inquiry line:** 1-866-220-5448, Monday through Friday from 8 a.m. to 5 p.m.

**CarePlus Provider Services Executive:** Upon initial contracting with CarePlus, a provider is assigned a provider services executive who serves as the liaison between the provider and CarePlus. Questions regarding membership, reports and/or issues relating to agreements should be directed to your provider services executive.
## KEY CONTACTS LIST

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<td><a href="https://pws.careplus-hp.com/ProvWS/MemberLU.asp">https://pws.careplus-hp.com/ProvWS/MemberLU.asp</a>&lt;br&gt;OR&lt;br&gt;Availity (<a href="http://www.availity.com">www.availity.com</a>)&lt;br&gt;OR&lt;br&gt;Change Healthcare (formerly Emdeon)&lt;br&gt;(<a href="http://changehealthcare.com">http://changehealthcare.com</a>)&lt;br&gt;OR&lt;br&gt;1-866-313-7587</td>
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<tr>
<td>Provider emergency hotline</td>
<td>1-877-210-5318</td>
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### AUTHORIZATIONS

| Telephonic requests                        | 1-800-201-4305                                                                      |                         |
| **Fax requests (precertification / outpatient)** | *(Dade)* 1-888-790-9999<br>(Broward and Palm Beach) 1-866-832-2678<br>(All other counties) 1-888-634-3521 |                         |
| All inpatient and observation notifications, census reports (if applicable), and clinicals | 1-866-229-1538                                                                      |                         |

*Authorizations for services that are covered under a capitated provider/network/delegate should be submitted directly to the provider network/delegate. (Please refer to the pages below included in the Additional Services Contact List.)*

| Claim status/inquiries                     | Availity (www.availity.com)<br>OR<br>Change Healthcare (formerly Emdeon)<br>(http://changehealthcare.com)<br>OR<br>Phone: 1-866-313-7587<br>Fax: 1-855-811-0408 |                         |
| Claims address                             | Availity (www.availity.com)<br>CarePlus Payer ID No. 95092<br>OR<br>P.O. Box 14697<br>Lexington, KY, 40512-4697 |                         |

<p>| Request copies of remits, checks, and eligibility verification | <a href="mailto:Provider.requests@careplus-hp.com">Provider.requests@careplus-hp.com</a> |                         |</p>
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<td>Laboratory services</td>
<td><strong>LabCorp of America (all counties)</strong> 1-800-788-3818 <a href="http://www.labcorp.com">www.labcorp.com</a></td>
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<tr>
<td>Pharmacy Technical Help Desk Call Center</td>
<td><strong>DST Pharmacy Solutions</strong> 1-800-522-7487</td>
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| Mental health | **Magellan Healthcare Inc. (all counties)**  
Phone: 1-800-424-1760 | **Members should contact Magellan Healthcare Inc. directly for appointments.**  
**Providers should contact Magellan Healthcare Inc. directly for mental health authorizations.** |
| Part D Oral Meds only | **Authorizations**  
Prior Authorizations and Exceptions  
Phone: 1-866-315-7587  
Fax: 1-800-310-9071 | **Part D Oral Meds only**  
**Authorizations**  
Prior Authorizations and Exceptions  
Authorization rules may apply for services.  
Contact plan for details.  
Authorization rules may apply for services.  
Contact plan for details. |
| DME | **One Homecare Solutions**  
(Broward, Indian River, Miami-Dade and Palm Beach)  
Phone: 1-855-441-6900  
Fax: 1-844-862-5486  
**Integrated Home Care Services**  
(Brevard, Clay, Duval, Hillsborough, Lake, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, Sumter and Volusia)  
Phone: 1-844-215-4264  
Fax: 1-844-215-4265 | Authorization rules may apply for services.  
Contact plan for details.  
Authorization rules may apply for services.  
Contact plan for details. |
| Home Infusion | **One Homecare Solutions**  
(all counties)  
Phone: 1-855-441-6900  
Fax: 1-844-862-5486 | Authorization rules may apply for services.  
Contact plan for details |
| Home Health | **One Homecare Solutions**  
(Broward, Indian River, Miami-Dade and Palm Beach)  
Phone: 1-855-441-6900  
Fax: 1-844-862-5486  
**Integrated Home Care Services**  
(Brevard, Clay, Duval, Hillsborough, | Authorization rules may apply for services.  
Contact plan for details  
Authorization rules may apply for services. |
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<td>Lake, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, Sumter and Volusia) Phone: 1-844-215-4264 Fax: 1-844-215-4265</td>
<td>Contact plan for details.</td>
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<td>Disposable/ Tracheotomy/ Mastectomy Supplies</td>
<td>Advance Care Solutions (all counties) Phone: 1-877-748-1977 Fax: 1-877-748-1985</td>
<td>For all ostomy, urological, tracheotomy, and mastectomy supplies</td>
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<td>Transportation</td>
<td>Alivi NEMT Network (all counties) 1-888-998-4640</td>
<td>Contact Alivi NEMT Network directly to schedule transportation. Authorization rules/exclusions may apply for services. Contact your provider services executive or the provider operations help line for details</td>
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<td>H2 Hospitalist Group, LLC (Broward, Dade and Palm Beach) 1-833-542-2273</td>
<td>The hospital is responsible for contacting the appropriate hospitalist company for admitting assignment. Contact plan for details or questions.</td>
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<td>TBIM Hospitalists (TBIM) (Hillsborough) 813-681-0340</td>
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<td>Osceola Internal Medicine (Osceola) 407-344-3933</td>
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<td>Mid Florida Hospital Specialist (Orange and Seminole) 321-207-0174</td>
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<td>Excel Hospitalist Group (Orange) 407-992-6999</td>
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<td>Greater Orlando Hospitalist Group (Orange and Seminole) 407-767-0727</td>
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<td>Central FL IM (Orange and Seminole) 321-397-2712</td>
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<td>Dr. William Muñoz</td>
<td>(Osceola) 407-248-8862</td>
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<td>Ethics Help Line</td>
<td>1-877-584-3539</td>
<td><a href="http://www.ethicshelpline.com">www.ethicshelpline.com</a></td>
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<tr>
<td>Fraud, Waste &amp; Abuse (FWA) Hotline</td>
<td>1-800-614-4126</td>
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For questions or inquiries relating to these services or services not listed above, please contact the Provider Operations inquiry line at:
1-866-220-5448

Our hours of operation are 8 a.m. to 5 p.m. Eastern time, Monday through Friday.

Remainder of this page intentionally left blank
For the purposes of this manual, the following words and phrases shall have the meaning specified below:

A. **CarePlus (CarePlus Health Plans Inc.)** a health maintenance organization (HMO) with a Medicare Advantage (MA) contract.

B. **Administrative Fee** means the amount subtracted from total monthly premiums received by CarePlus or on behalf of enrollees in each line of business (e.g., Medicare) and retained by CarePlus for administration. The amount of the administrative fee is set forth in your PCP agreement.

C. **BFCC-QIO (Beneficiary and Family Centered Care Quality Improvement Organization)** means an organization comprised of practicing doctors and other healthcare experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. BFCC-QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials for enrollees receiving acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities (SNFs), home health agencies (HHAs) and/or comprehensive outpatient rehabilitation facilities (CORFs).

D. **Calendar Quarter** means any of the three-month periods from Jan. 1 through March 31, April 1 through June 30, July 1 through Sept. 30, and Oct. 1 through Dec. 31.

E. **Capitation Fee** means the monthly payment made by CarePlus to the provider for each enrollee assigned to provider. The amount of the capitation fee is set forth in the provider agreement.

F. **Clean Claim** is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-contracted providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. A claim is “clean” even if CarePlus refers it to a medical specialist for examination. If additional documentation in the medical record involves a source outside CarePlus, the claim will not be considered “clean.”

G. **Copayment** means the amount required to be paid by member to provider as additional payments for covered services as are medically necessary pursuant to Section 1.23 of this agreement and shall include fixed payments to be paid as well as percentage amounts based on the cost of a service (i.e. co-insurance). Copayments will vary in amount for members, depending on benefit structure.

H. **Covered Services** means all medical services and other benefits required to be provided to members by CarePlus under its agreement(s) with Medicare and under the terms of CarePlus’ agreements with members, including, without limitation, primary care, specialist medical services, hospital services, ancillary and diagnostic services, and emergency medical services. Covered services are subject to change any time as required by applicable law or under CarePlus’ Medicare agreement(s).

I. **Covering Provider** means a physician who will continue to render covered services to members during those times when provider cannot provide these services as set forth in this agreement, but is doing so under the same terms of this agreement.

J. **Emergency Medical Condition** means (a) a medical condition manifesting itself by acute
symptoms of sufficient severity (including severe pain) such that a prudent layperson, pursuant to Section 4704 of the 1997 Balanced Budget Act, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

(1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
(2) Serious impairment to bodily functions
(3) Serious dysfunction of any bodily organ or part

K. **Emergency Services** means covered inpatient and outpatient services that are:

(1) Furnished by a provider qualified to furnish emergency services
(2) Needed to evaluate or stabilize an emergency medical condition

L. **Grievance** means expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of an appeal of an organization determination or coverage determination or an LEP determination.

M. **Interdisciplinary Care Team or ICT** refers to interdisciplinary services provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient’s significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional also is expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient’s significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize and achieve treatment goals.

N. **MA Organization** means a public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider-sponsored organization receiving waivers) that is certified by CMS as meeting the MA contract.

O. **MA Plan** means medical benefits coverage offered under a policy or contract by an MA organization that includes specific set of health benefits offered at a uniform premium and uniform level cost-sharing to all Medicare beneficiary residing in the service areas (or segment of the service area) of the MA plan.

P. **MA Plan Enrollee** means an MA eligible individual who has elected an MA plan offered by an MA organization.

Q. **MA-Prescription Drug Plan (MA-PD Plan)** means an MA plan that provides qualified prescription drug coverage and Part A and Part B benefits in one plan.

R. **Medicaid** is a joint federal and state program that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of people who might otherwise go without medical care for themselves. Medicaid is different in every state. In Florida, the Agency for
Health Care Administration (AHCA) develops and carries out policies related to the Medicaid program.

S. **Medicaid Fiscal Agent** refers to the state Medicaid program’s vendor contracted to serve as the state’s fiscal agent. Some of the fiscal agent functions include enrolling non-institutional providers, processing Medicaid claims, serving as the enrollment broker for Medicaid recipients, and distributing Medicaid forms and publications.

T. **Medical Director** means a physician designated by CarePlus to monitor and review covered services provided by a healthcare provider to members or requested by a healthcare provider for members.

U. **Medical Group** means a group of PCP and/or specialist physicians who:

1. are formally organized as a partnership or professional corporation;
2. provide for the diagnosis or direct care and treatment of a medical condition
3. divide their income based on a specified, fixed formula.

V. **Medically Necessary** is determined by CarePlus’ medical director and includes consideration of whether services:

1. are appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition
2. provide for the diagnosis or direct care and treatment of a medical condition
3. are not primarily for the convenience of the enrollee, the enrollee’s attending or consulting physician, or another healthcare provider

W. **Member (Member of our Plan, or Plan Member)** means a person with Medicare who is eligible to receive covered services who has enrolled in CarePlus and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

X. **Model of Care (MOC)** is an approved CMS document where Medicare Advantage plans outline their basic framework to support a special needs plan (SNP) in meeting the needs of each of its members. The MOC provides the needed infrastructure to promote quality, care management and care coordination processes for SNPs.

Y. **Participating Hospital** means a hospital that has entered into a contractual agreement with CarePlus to serve enrollees.

Z. **Participating Physician** means any physician licensed to practice in the state of Florida who satisfies the participation criteria established by CarePlus and who has entered into a contractual arrangement with, or is otherwise engaged by, CarePlus to provide physician services to enrollees.

AA. **Participating Provider** means a participating physician, a participating hospital, or other healthcare professional or provider that has entered into a contractual agreement with CarePlus to serve enrollees.

BB. **Primary Care Physician (PCP)** means a participating physician who supervises, coordinates and provides primary care services to enrollees, including the initiation of their referral for specialist
services and other non-PCP services, and who meets all the other requirements for PCP contained in CarePlus’ rules and regulations and in the primary care physician agreement.

CC. **Primary Care Services** means covered services customarily provided by a PCP in his or her office as well as services customarily provided by an attending PCP to institutionalized patients. This includes, by way of example and not limitation, the primary care services as set forth in Attachment “A” of the PCP agreement.

DD. **Reserve** means an amount segregated within the claims fund estimated by CarePlus to be sufficient to satisfy claims that have been incurred but not reported, based upon historical experience for CarePlus enrollees. The reserve amount shall be determined by CarePlus.

EE. **Service Area for Medicare** means a geographic area approved by CMS within which an MA-eligible individual may enroll in a particular plan offered by CarePlus.

FF. **Special Needs Plans or SNPs** were created via the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed-care plan focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, Medicare/Medicaid dual-eligibles and beneficiaries with severe or disabling chronic conditions. SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs through improved coordination and continuity of care and by combining benefits available through Medicare and Medicaid.

GG. **Specialist Physician** means a participating physician who is board certified or has met the academic requirements to sit for the board in a certain medical specialty; who provides services to enrollees within the range of such specialty; who elects to be designated as a specialist physician by CarePlus; and who meets all other requirements for specialist physicians contained in CarePlus’ rules and regulations and in the agreement between CarePlus and the specialist physician.

HH. **Specialist Services** means those services of a specialist physician, within the scope of his/her board-certified or board-eligible specialty, that are:

1. provided upon the referral of a PCP pursuant to CarePlus’ rules and regulations
2. covered services, but not PCP services

II. **Urgently Needed Services** means covered services provided when a member is temporarily absent from the plan’s service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the member is in the service or continuation area but a participating provider is temporarily unavailable or inaccessible) when such covered services are medically necessary and immediately required:

1. as a result of an unforeseen illness, injury, or condition
2. it was not reasonable given the circumstances to obtain the covered services through a participating provider.

JJ. **Urgent Care** means care provided for those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received or substantially restrict a member's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).
Responsibilities of CarePlus

CarePlus under its agreement with its contracted providers is responsible for the following:

A. Assist contracted providers in meeting the expectations of the health plan;
B. Maintain a record of eligibility for all enrolled members;
C. Process all enrollment and disenrollment applications;
D. Educate and encourage enrolled members to be seen for appropriate preventive services;
E. Keep contracted providers informed of any changes set forth by the Centers for Medicare & Medicaid Services (CMS);
F. Prepare necessary reports required for the maintenance of the health plan;
G. Make member service representatives available to handle all concerns and issues members may have;
H. Provide contracted providers support by having provider services executives to handle issues regarding agreement and general concerns;
I. Provide training and support in the application of utilization review programs and the development of a network of contracted providers;
J. Serve as a referral support center, to assist in the provision of any service by a specialty provider, as requested by the affiliated provider;
K. Perform periodic site-visits to primary care physicians (PCP) offices and high volume specialists to ensure compliance with the CarePlus’ established procedures access to information and response to inquiries concerning issues that may relate to quality of care;
L. Maintain and monitor a panel of primary care providers from which the member may select a primary care physician;
M. Consult and communicate with physicians regarding CarePlus’ medical policy, quality assurance/improvement programs and medical management procedures;
N. Agree to comply with federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but limited to, applicable provisions of federal criminal law, the False Claims ACT (31 USC 3729 et. Seq.), and the anti-kickback statute (section 1128B (b)) of the ACT;
O. Disclose to CMS all information necessary to (1) administer and evaluate the program; and (2) establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services;
P. Maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and
conditions with its contract with CMS. Require its related entities, contractors and subcontractors grant the U.S. Department of Health and Human Services (HHS), the comptroller general or their designee the right to inspect, evaluate, and audit any pertinent information for any particular contract period and maintain this information for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later;

Q. Communicate and certify the truthfulness and completeness of encounter data and medical records submitted by the plan and its affiliated physicians, contractors, and subcontractors;

R. Agrees to arrange through its contracted physicians continuation of members healthcare benefits for the duration of the contract period with CMS; and provide continuation of care for members who are hospitalized on the date should the contract terminate, or, in the event of insolvency, through discharge;

S. Notify prospective and participating providers in writing the reason for denial, suspension and termination from the plan;

T. Shall not discriminate against provider with respect to participation, reimbursement, or indemnification so long as provider is acting within the scope of his/her licensure or certification under applicable state law, solely on the basis of such license or certification. This provision shall not be construed as an “any willing provider law,” as it does not prohibit CarePlus from limiting provider participation to the extent necessary to meet the needs of its members;

U. Shall not discriminate against provider when serving high-risk populations or when provider specializes in conditions requiring costly treatments.

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In addition to the provisions mentioned above, CarePlus must include certain MA-related provisions in the policies and procedures that are distributed to providers and suppliers that constitute the organizations’ health services delivery network. The following table summarizes these provisions, which may be accessed online by viewing the Code of Federal Regulations (CFR) which is available on the U.S. Government Printing Office website (www.gpo.gov).

<table>
<thead>
<tr>
<th>Summary of CMS Requirement</th>
<th>Title 42 &gt; Chapter IV &gt; Subchapter B &gt; Part 422 &gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguard privacy and maintain records accurately and timely</td>
<td>422.118</td>
</tr>
<tr>
<td>Permanent “out of area” members to receive benefits in continuation area</td>
<td>422.54(b)</td>
</tr>
<tr>
<td>Prohibition against discrimination based on health status</td>
<td>422.110(a)</td>
</tr>
<tr>
<td>Pay for emergency and urgently needed services</td>
<td>422.100(b)</td>
</tr>
<tr>
<td>Pay for renal dialysis for those temporarily out of a service area</td>
<td>422.100(b)(1)(iv)</td>
</tr>
<tr>
<td>Direct access to mammography and influenza vaccinations</td>
<td>422.100(g)(1)</td>
</tr>
<tr>
<td>No copay for influenza and pneumococcal vaccines</td>
<td>422.100(g)(2)</td>
</tr>
<tr>
<td>Agreements with providers to demonstrate “adequate” access</td>
<td>422.112(a)(1)</td>
</tr>
<tr>
<td>Direct access to women's specialists for routine and preventive services</td>
<td>422.112(a)(3)</td>
</tr>
<tr>
<td>Services available 24 hours a day, seven days a week</td>
<td>422.112(a)(7)</td>
</tr>
<tr>
<td>Adhere to CMS marketing provisions</td>
<td>422.80(a), (b), (c)</td>
</tr>
<tr>
<td>Ensure services are provided in a culturally competent manner</td>
<td>422.112(a)(8)</td>
</tr>
<tr>
<td>Maintain procedures to inform members of follow-up care or provide training in self-care as necessary</td>
<td>422.112(b)(5)</td>
</tr>
<tr>
<td>Document in a prominent place in medical record if individual has executed advance directive</td>
<td>422.128(b)(1)(ii)(E)</td>
</tr>
<tr>
<td>Provide services in a manner consistent with professionally recognized standards of care</td>
<td>422.504(a)(3)(iii)</td>
</tr>
<tr>
<td>Continuation of benefits provisions (may be met in several ways, including contract provision)</td>
<td>422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)</td>
</tr>
<tr>
<td>Payment and incentive arrangements specified</td>
<td>422.208</td>
</tr>
<tr>
<td>Subject to applicable federal laws</td>
<td>422.504(h)</td>
</tr>
<tr>
<td>Disclose to CMS all information necessary to (1) administer and evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services</td>
<td>422.64(a); 422.504(a)(4) 422.504(f)(2)</td>
</tr>
</tbody>
</table>
### Summary of CMS Requirement

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must make good faith effort to notify all affected members of the termination of a provider contract 30 calendar days before the termination by plan or provider</td>
<td>Title 42 &gt; Chapter IV &gt; Subchapter B &gt; Part 422 &gt; 422.111(e)</td>
</tr>
<tr>
<td>Submission of data, medical records and certify completeness and truthfulness</td>
<td>422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)</td>
</tr>
<tr>
<td>Comply with medical policy, QI, and MM</td>
<td>422.202(b); 422.504(a)(5)</td>
</tr>
<tr>
<td>Disclose to CMS quality and performance indicators for plan benefits regarding disenrollment rates for beneficiaries enrolled in the plan for the previous two years</td>
<td>422.504(f)(2)(iv)(A)</td>
</tr>
<tr>
<td>Disclose to CMS quality and performance indicators for the benefits under the plan regarding enrollee satisfaction</td>
<td>422.504(f)(2)(iv)(B)</td>
</tr>
<tr>
<td>Disclose to CMS quality and performance indicators for the benefits under the plan regarding health outcomes</td>
<td>422.504(f)(2)(iv)(C)</td>
</tr>
<tr>
<td>Notify providers, in writing, of reason for denial, suspension and termination</td>
<td>422.202(c)(1)</td>
</tr>
<tr>
<td>Provide 60 days’ notice when terminating contract without cause</td>
<td>422.202(c)(4)</td>
</tr>
<tr>
<td>Comply with federal laws and regulations to include, but not limited to: federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)</td>
<td>422.504(h)(1)</td>
</tr>
<tr>
<td>Prohibition of use of excluded practitioners</td>
<td>422.752(a)(8)</td>
</tr>
<tr>
<td>Adhere to appeals/grievance procedures</td>
<td>422.562(a)</td>
</tr>
</tbody>
</table>

**Source:** Medicare Managed Care Manual, Chapter 11, “Medicare Advantage Application Procedures and Contract Requirements,” § 100.4 – Provider and Supplier Contract Requirements. (Revised 04/25/07)

The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government. It is divided into 50 titles that represent broad areas subject to federal regulation. Each title is divided into chapters, which usually bear the name of the issuing agency. Each chapter is further subdivided into parts that cover specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations in the CFR are provided at the section level.

The MA-related provision can be found under title 42. Example: 42 CFR 422.111

GENERAL COMPLIANCE AND FRAUD, WASTE AND ABUSE REQUIREMENTS

CarePlus is committed to maintaining high ethical standards and conducting business with integrity and in compliance with applicable laws, regulations and requirements. This strong commitment to ethics is the foundation of CarePlus’ business relationships. The Centers for Medicare & Medicaid Services (CMS) mandates that all CarePlus-contracted entities complete compliance requirements. As a wholly owned subsidiary of Humana, CarePlus is providing two Humana documents: Compliance Policy for Contracted Healthcare Providers and Third Parties and Ethics Every Day for Contracted Healthcare Providers and Third Parties. As such, you will see references to Humana throughout these documents. In addition, CMS requires education on the topic of fraud, waste and abuse (FWA) be provided to all who support a (CarePlus-administered) Medicare plan, such as your organization’s employees, both administrative and healthcare professionals, and, if applicable, any other individuals and entities supporting your organization in meeting contractual obligations to CarePlus.

The Humana documents are available on the CarePlus website: https://www.careplushealthplans.com/careplus-providers/compliance. If you are unable to access the internet, please contact our Provider Operations inquiry line at 1-866-220-5448, Monday through Friday, from 8 a.m. to 5 p.m. Eastern time.

CarePlus suggests the educational requirements outlined above occur within 30 days of contract or hire and annually thereafter. Review of these two documents, or materially similar documents, and FWA training is required of healthcare providers and those supporting their contract with CarePlus so sufficient awareness is gained of the compliance requirements. CarePlus reserves the right to request that contracted healthcare providers and those in their organizations supporting a CarePlus contract provide evidence of distribution of the above documents or materially similar content, as well as tracking logs and documentation related to any other requirements the documents outline.

We appreciate your assistance with this requirement! Thank you for your care of our members.

Notable Changes
Two core compliance program documents have updated titles:
- New title: Compliance Policy for Contracted Healthcare Providers and Third Parties
- Previous title: Compliance Policy for Contracted Healthcare Providers and Business Partners
- New title: Ethics Every Day for Contracted Healthcare Providers and Third Parties
- Previous title: Ethics Every Day for Contracted Healthcare Providers and Business Partners

If you have any questions about this compliance program and training requirement, please contact your assigned provider services executive or the Provider Operations inquiry line at 1-866-220-5448, Monday through Friday from 8 a.m. to 5 p.m. Eastern time.

Contracted providers are responsible for complying with all applicable laws, regulations and CarePlus’ policies and procedures, including, but not limited to the Compliance Policy for Contracted Healthcare Providers and Third Parties (“Compliance Policy”), Ethics Every Day for Contracted Healthcare Providers and Third Parties (“Ethics Every Day,”) and FWA Training. The Humana documents are available on the CarePlus website at https://www.careplushealthplans.com/careplus-providers/compliance.

The Humana documents incorporate requirements outlined by CMS for all Medicare Advantage (MA) or prescription drug plans (PDP) sponsors, as well as, any individuals and entities that provide administrative support, related materials/supplies and/or render services for or on behalf of the sponsors,
as detailed in Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual.

CarePlus’ general compliance and FWA requirements for contracted providers, include, but are not limited to:

1. Having designated resource(s) to fulfill compliance obligations

2. Being familiar with CarePlus’ expectations and requirements relating to compliance program requirements and FWA prevention, detection and correction, which have been outlined in the CMS Training, Compliance Policy and Ethics Every Day.

3. Monitoring the compliance of employees.

4. Monitoring and auditing the compliance of subcontractors that provide services or support related to administrative or healthcare services provided to a member of CarePlus (“downstream entities”).

5. Obtaining approval from CarePlus for any relationships with downstream entities. In addition, note that CarePlus must notify CMS of any location outside of the United States or a United States’ territory that receives, processes, transfers, stores or accesses a Medicare member’s protected health information in oral, written or electronic form.

6. Reporting instances of suspected and/or detected FWA and noncompliance with the Compliance Policy and Ethics Every Day.

7. Having policies and procedures in place for preventing, detecting, correcting and reporting noncompliance and FWA, including, but not limited to:
   
   a. Requiring employees and downstream entities to report suspected and/or detected FWA and noncompliance
   b. Safeguarding CarePlus’ confidential and proprietary information
   c. Providing accurate and timely information/data in the regular course of business
   d. Screening all employees and downstream entities against federal government exclusion lists, including the Office of Inspector General (OIG) list of Excluded Individuals and Entities (https://oig.hhs.gov/exclusions/) and the General Services Administration (GSA) Excluded Parties Lists System (www.sam.gov). Anyone listed on one or both of these lists is not eligible to support CarePlus’ Medicare Advantage and Prescription Drug plans, must be removed immediately from providing services or support to CarePlus, and CarePlus must be notified upon such identification.

8. Cooperating fully with any investigation of alleged, suspected or detected violation of the manual, CarePlus policies and procedures, or applicable state or federal laws or regulations, and/or remedial actions.

9. Administering compliance and FWA training to employees and downstream entities including, but not limited to:
   
   a. Documenting that training requirements have been met; and
b. Having a system in place to collect and maintain records of compliance and FWA training for a period of at least 11 years.

10. Publicizing disciplinary standards to employees and downstream entities.

11. Instituting disciplinary standards and taking appropriate action upon discovery of noncompliance, FWA or actions likely to lead to either one.

12. Avoiding conflicts of interest, having an internal policy in place to identify and disclose and address conflicts of interest and, upon request, providing CarePlus with conflict of interest statements covering the provider, employees and downstream entities.

Additional information can be found online in the Compliance Policy and Ethics Every Day at https://www.careplushealthplans.com/careplus-providers/compliance.

REPORTING METHODS FOR SUSPECTED OR DETECTED NONCOMPLIANCE

Contracted providers, their employees, and downstream entities are required to notify our parent organization, Humana’s Special Investigations Unit (SIU) of suspected or detected FWA. Information about SIU and CarePlus’/Humana’s efforts to prevent, detect and correct FWA can be found on the CarePlus website (https://www.careplushealthplans.com/careplus-providers/compliance) and in Ethics Every Day, the compliance policy, and FWA training. Providers, their employees, and downstream entities also may report concerns and information related to FWA and noncompliance with this manual, Ethics Every Day, and/or compliance policy to our parent organization, Humana, via the following anonymous options:

- Special Investigations Unit Direct Line: 1-800-558-4444, ext. 8187 (Monday-Friday, 8 a.m.-5:30 p.m. Eastern time);
- Special Investigations Hotline (voice messaging system): 1-800-614-4126 (24/7 access);
- Special Investigations Unit fax line: 920-339-3613
- Ethics Help Line: 1-877-5-THE-KEY (1-877-584-3539);
- Email: siureferrals@humana.com or ethics@humana.com; or
- Web: www.ethicshelpline.com

Individuals and entities that report suspected or detected false claims violations are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. CarePlus prohibits intimidation of and retaliation against those who in good faith report suspected or detected violations of CarePlus’ policies and has zero tolerance for retaliation or retribution against any person who reports suspected misconduct.

Once SIU performs its initial investigation, SIU may refer the case to the appropriate law enforcement and/or regulatory agencies, including, but not limited to, the appropriate CMS regional office, as SIU deems appropriate.

DISCIPLINARY STANDARDS

Confirmed noncompliance and/or FWA violations by healthcare providers, their employees and/or downstream entities could result in any or all of the following:
Oral or written warnings or reprimands
Suspensions or termination(s) of employment or agreement
Other measures which may be outlined in the agreement
Mandatory retraining
Written corrective action plan(s) that must be completed to closure; and/or
Reporting of the conduct to the appropriate external entities, such as CMS, a CMS designee, and/or law enforcement agencies

REPORTING OCCURRENCES TO CAREPLUS

Pursuant to Florida Statute 641.55 and, Florida Administrative Code Rule 59A-10, the Agency for Health Care Administration (AHCA) mandates that an HMO maintain an internal risk management program. As part of the CarePlus Risk Management Program, physicians and other healthcare providers are expected to report any occurrences and/or adverse incidents involving a CarePlus member, whether it happens in their office or in any other facility.

An occurrence is defined as any unforeseen complication or unusual event in which a plan member is involved. Examples of occurrences are:

- Complication of drug, treatment, or service prescribed
- Dissatisfaction angrily expressed with threats
- Delay in care, diagnosis or referral
- Breach of confidentiality
- Receipt of a Notice of Intent to initiate litigation against a contracted physician or facility

An adverse incident is defined as an event over which healthcare personnel could exercise control and which is associated in whole, or in part with medical intervention rather than the condition for which such intervention occurred and which results in one of the following:

- Unexpected death of a patient
- Brain or spinal damage
- Performance of surgical procedure on the wrong patient
- Performance of a wrong site surgical procedure
- Performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient’s diagnosis or medical condition
- Surgical repair of damage resulting to a patient from a planned procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
- Performance of procedure to remove unplanned foreign objects remaining from a surgical procedure
- Never Events – per CMS guidelines

As per Florida Administrative Code R. 59A-12.012, occurrences and adverse incidents must be reported to the CarePlus risk manager within three calendar days. The information submitted to CarePlus is used for state-mandated risk management review.
Independent physicians or private practice physicians and their health plan medical director should report occurrences and adverse incidents using one of the following methods:

- Telephonically between the independent physician and the health plan medical director
- Telephonically between the office staff and the health plan risk manager or provider representative
- In writing by completing a Member Occurrence Report, filled out by the independent physician or office staff. For your convenience we have included a copy of the Member Occurrence Report under the “Forms” section of this manual. The report should be mailed to the risk manager, medical director, or the designated provider services executive. Facsimiles should be avoided because of lack of confidentiality.

Group physicians and their staffs should use the following methods:

- Telephonically between the group medical director/group leader and the health plan medical director. (The group physician, who becomes aware of an occurrence, should report the occurrence to the group medical director/group physician leader)
- Telephonically between the office staff and the health plan risk manager or provider representative
- In writing by completing a Member Occurrence Report filled out by the group medical director/group physician leader or office staff. The report should be mailed to the risk manager, medical director, or the designated provider representative. Facsimiles should be avoided because of lack of confidentiality

Note: Allied healthcare professionals should report to their supervising physician. All other healthcare providers should report as independent physicians.

The information submitted to the plan is used to investigate potential quality issues and for risk management review. All information reported to the plan will remain strictly confidential in accordance with the policy and procedure on confidentiality.

If you have any questions regarding the above-mentioned information or would like to obtain guidance on how to establish a risk management program within your facility, please contact CarePlus’ Risk Management department at 1-855-281-6067, Monday through Friday, 8 a.m. to 5 p.m.
RESPONSIBILITIES OF THE FACILITY

1. Facility must have 24 hours a day, seven days a week coverage and regular hours of operation should be clearly defined and communicated to the members.

2. Facility agrees to provide services ethically and legally and provide all services in a culturally competent manner consistent with professionally recognized standards of care, accommodate those with disabilities, and not discriminate against anyone based on race, ethnicity, national origin, religion, sex, age, marital status, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence) genetic information or source of payment.

3. Facility shall participate in any system established by CarePlus to facilitate the sharing of records (subject to applicable confidentiality requirements in accordance with 42 CFR, Part 431, Subpart F, including a minor’s consultation, examination and drugs for S&D in accordance with Section 384.30(2), FS).

4. Facility agrees to provide services in a culturally competent manner, i.e., removing all language barriers. Care and services should accommodate the special needs of ethnic, cultural, and social circumstances of the patient.

5. Facility agrees to refer and/or admit CarePlus members only to participating hospitals, skilled nursing facilities (SNFs) and other facilities except when participating hospitals, SNFs and other facilities are not available in network or in an emergency.

6. Facility agrees to participate and cooperate with CarePlus in any reasonable internal and external quality assurance/quality improvement, utilization review, continuing education and other similar programs established by CarePlus if it is customarily provided by facility.

7. Facility agrees to participate in, and cooperate with, CarePlus’ grievance/appeal procedures when CarePlus notifies facility of any member grievances/appeals.

8. Facility agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any resources against CarePlus member other than for copayments, or fees from non-covered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare or services excluded in the member’s Evidence of Coverage. Notification that a service is not a covered benefit must be provided to the member prior to the service and be consistent with CarePlus policy, in order for the member to be held financially responsible. CarePlus policy requires that the notification include the date and description of the service, an estimate of the cost to the member for such services, name and signature of the member agreeing in writing of receiving such services, name and signature of the provider, and be in at least 12-point font. Documentation of that pre-service notification must be included in the member’s medical record and shall be provided to CarePlus or its designee upon request, and in a timely manner to substantiate member appeals.

9. All facilities must continue care in progress during and after the termination period.

10. Facility agrees to treat all member records and information confidentially, accurately, timely, and not release such information without the written consent of the member, except as indicted herein, or as needed for compliance with state and federal laws, including HIPAA regulations.
RESPONSIBILITIES OF THE FACILITY

11. Facility agrees to have onsite written policies and procedures that are reviewed and updated annually, to include an evaluation for the availability of safer medical services and devices, as well as, changes in technology. Office policies and procedures should include, but not be limited to, the following:
   - Appointment scheduling and telephone guidelines
   - Recordkeeping and general documentation requirements
   - Medical records and confidentiality (e.g., HIPAA)
   - Medication administration (e.g., refill policies, controlled substances, etc.)
   - Infection control (e.g., bloodborne pathogens, housekeeping, sharps safety, hand hygiene, written exposure control plan)
   - Safety program
   - Hazard communications.
   - Hazardous drugs plan.
   - Fire safety
   - Emergency action plans and preparedness (i.e., fire, tornado and workplace violence)

12. Facility agrees to establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.

13. Facility agrees to support and cooperate with CarePlus’ Quality Improvement Program to provide quality care in a cost-effective and reasonable manner if consistent with facility’s operations.

14. Facility agrees to inform CarePlus if member objects to provision of any counseling, treatments, or referral services on religious grounds.

15. Facility agrees to treat all members with respect and dignity, to provide them with appropriate privacy and treat member disclosures and records confidentially giving the members the opportunity to approve or refuse their release.

16. Facility agrees to provide to the members complete information concerning their diagnosis, evaluation, treatment and prognosis and the use of the healthcare system. Facility will give the members the opportunity to participate in decisions involving their healthcare except when contraindicated for medical reasons.

17. When clinically indicated, facility agrees to contact CarePlus members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.

18. When the need arises, patients will be transferred to another provider. Facility agrees to an adequate transfer of information when members are transferred to other healthcare providers with a completed signed release from the member.

19. Food snacks or services provided to patients should meet their clinical needs and should be prepared, stored, secured and disposed of in compliance with local health department requirements.

20. Facility agrees to have a policy and procedure to ensure proper identification, handling, transport,
RESPONSIBILITIES OF THE FACILITY

treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection in the facility.

21. Facility agrees to establish procedures to obtain, identify, store, and transport laboratory specimens or biological products, when applicable.

22. Facility agrees to establish procedures to notify public health authorities of reportable or communicable conditions.

23. Facility agrees to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high quality patient care.

24. Facility agrees that any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of non-research related care.

25. Facility agrees to provide to plan a copy of any changes to the facility’s charge master.

26. Facility agrees to notify plan within twenty-four (24) hours after facility becomes aware of the admission and identification of the member as inpatient.

27. Facility agrees to cooperate with an independent quality improvement organization’s activities pertaining to the provision of services for CarePlus members. The facility also agrees to respond expeditiously to CarePlus’ request for medical records or any other documents in order to comply with regulatory requirements, and to provide any additional information when necessary to resolve/respond to a member’s grievance or appeal.

28. Facility agrees to retain all agreements, books, documents, papers, and medical records related to the provision of services to plan members are required by state and federal laws.

29. Facility agrees to comply with applicable state and federal laws and regulations to include, but not limited to: federal criminal law, the False Claims Act (31 USC 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act), Title VI of the Civil rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

30. Facility agrees that in the event CarePlus denies payment of health service(s) rendered to CarePlus members determined not to be medically necessary, the facility will not bill, charge, seek payment or have any recourse against said member for such service(s), unless the member has been advised in advance that the service(s) is/are not medically necessary and has agreed in writing to be financially responsible for those services pursuant to CarePlus policy (see No.7 for details).

Facility Responsibilities under Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990

Title VI of the Civil Rights Act of 1964
Title VI of the Civil Rights Act of 1964 prohibits against national origin discrimination, which protects individuals with limited English proficiency (LEP). It applies to all entities that receive Federal financial assistance, either directly or indirectly (e.g., through a grant, cooperative agreement, contract/subcontract, Medicaid and Medicare payments, etc.). Virtually all healthcare providers must ensure that LEP patients have meaningful access to healthcare services at no cost to the patient. “Meaningful access” means that the LEP patient can communicate effectively.

In 2003, the U.S. Department of Health and Human Services (DHHS) issued guidance to assist healthcare providers in complying with Title VI. The DHHS points out that a thorough assessment of the language needs of the population served is to be conducted in order to develop appropriate and reasonable language assistance measures. The guidance details four factors providers should consider when determining the extent and types of language assistance that may be pursued:

1. The number or proportion of LEP individuals eligible to be served or likely to be encountered
2. The frequency with which the LEP individuals come into contact with the provider
3. The nature and importance of the program, activity or service provided by the provider to people’s lives
4. The resources available to the provider and costs

A facility must have an appropriate response for the LEP patients they serve, such as, use of translated documents, bilingual office staff, and/or use of family members or an interpreter, when necessary. In the event a facility is unable to arrange for language translation services for non-English speaking or LEP CarePlus members, he/she may contact our member services department at 1-800-794-5907, and a representative will assist in locating a qualified interpreter via telephone who communicates in the member’s primary language while the member is in the office. To avoid having the member experience delay during the scheduled appointment, it is recommended that this be coordinated with the member services department prior to the date of the visit.

For additional information regarding improving cultural competency when providing care, please refer to the section titled Cultural Gaps in Care within this manual.

Furthermore, Section 1557 of the Patient Protection and Affordable Care Act strengthened requirements for language resources providing that individuals cannot be denied access to health care or health care coverage or otherwise be subject to discrimination because of race, color, national origin, sex, age, or disability. Under a new requirement, covered entities are required to post information telling consumers about their rights and telling consumers with disabilities and consumers with limited English proficiency (LEP) about the right to receive communication assistance. To reduce burden and costs, the HHS Office for Civil Rights (OCR) has translated a sample notice and taglines for use by covered entities into 64 languages. For translated materials, visit www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

Additional Resources to assist you in serving LEP patients:


U.S. DHHS Office of Civil Rights – Section 1557 of the Patient Protection and Affordable Care Act
https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

U.S. DHHS Office of Civil Rights – Section 1557: Frequently Asked Questions
https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html

The Americans with Disabilities Act of 1990
Under the ADA, facilities are considered places of public accommodation. Providers of medical services are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation and unequal treatment of any person with a disability. All facilities must have in operation: (i) handicapped accessibility, including an accessible exam table and adequate space and supplies; (ii) good sanitation; (iii) fire safety procedures. To provide medical services in an accessible manner, facilities and their staff may need training in operating accessible equipment, helping with transfers and positioning, and not discriminating against individuals with disabilities.

Facilities must furnish appropriate auxiliary aids and services where necessary to ensure effective communication. For deaf or hard-of-hearing patients, this may include written notes, readers, and telecommunication devices or an interpreter. In situations where information is more complex, such as discussing medical history or providing complex instructions about medications an interpreter should be present. If the information is simple and direct, such as prescribing an X-ray, providers may be able to communicate in writing.

For the visually impaired, this may include providing materials in large print or Braille text. In addition, the ADA requires that service dogs be admitted to healthcare provider offices unless it would result in a fundamental alteration or jeopardize safe operation. The cost of an auxiliary aid or service must be absorbed by the provider and cannot be charged to the member either directly or through CarePlus. Facilities are required to modify policies and procedure when necessary to serve a person with disability. However, the ADA does not require providers to make changes that would fundamentally alter the nature of their service. Facilities are responsible for making reasonable efforts to accommodate members with sensory impairments. Without these, facilities and their office staff might not understand the patient’s symptoms and misdiagnose medical problems or prescribe inappropriate treatment.

Additional Resources:


Language Assistance and Interpretation Services
Providers of medical services are contractually and federally required to ensure “equality of opportunity for meaningful access” to healthcare services and activities. This includes ensuring that non-English/limited English and disabled members are provided effective communication of vital information during doctor visits/appointments/follow-ups to avoid consequences or adverse risk to the patient/member (i.e. over the phone interpretation, video interpretation, in-person interpretation (including American Sign Language). Oral interpretation services must be provided, at no cost, in the language of the member (this includes American Sign Language).

More than 300 languages are spoken in the United States. To ensure “equality of opportunity for meaningful access to healthcare services and activities” (Executive Order 13166, Section 504/508 of Rehabilitation Act and Title III of ADA, Section 1557 of Patient Protection and Affordable Care Act)
providers must ensure patients/members are not discriminated against by not receiving effective communication.

When creating appointments with members (current and future), facilities must provide:

- Notification of availability of oral interpretation (over the phone, video or in-person) for non-English/limited English appointments.
- Notification of availability of video or in-person sign language interpretation for hearing impaired members.
- Voiance, an over-the-phone and video interpreter vendor, has set up a no-contract, offers interpretation services in 200 languages and video interpretation in 24 languages (including American Sign Language) to meet providers’ contractual and federal requirements. Please click the link below:
- Deaf-interpreters has an in-person sign language service available across the United States to make it easy for providers to meet ADA requirements regarding hearing impaired patients. www.deaf-interpreter.com.

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SUMMARY OF THE FLORIDA PATIENT’S BILL OF RIGHTS AND RESPONSIBILITIES

NOTE: All providers are required to post this summary in their offices.

Florida Law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare provider’s or healthcare facility’s right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare provider or healthcare facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the healthcare facility or provider’s office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her healthcare provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
- A patient as the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
- A patient is responsible for reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the healthcare provider.
- A patient is responsible for keeping appointments, and when he or she is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the healthcare provider’s instructions.
- A patient is responsible for assuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible.
- A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.
PLAN MEMBERSHIP AND ELIGIBILITY INFORMATION

CarePlus operations focus on service to members and quality of care. It is essential to comply with policies and procedures to ensure complete member satisfaction and the successful delivery of services.

This section of the manual explains the responsibility of the affiliated provider pertaining to enrollment, member identification card, eligibility, transfers and disenrollment.

MEMBER ELIGIBILITY

Medicare beneficiaries are eligible to enroll in an HMO if they are entitled to Medicare Part A and enrolled in Part B (enrollment for Part B only entitlement beneficiaries were allowed only prior to Dec. 31, 1998).

CarePlus’ eligibility verification does not guarantee payment. If CarePlus subsequently learns that the member was ineligible on the date of verification, no payment will be made. Therefore, it is important that physicians/providers always ask patient for his/her most recent insurance status.

MY CAREPLUS MEMBER PORTAL

CarePlus members can access information via “MyCarePlus,” a secure online member portal. Members can register for MyCarePlus from the home page of our website, www.CarePlusHealthPlans.com, or go directly to www.GoMyCarePlus.com. After creating a member portal account and logging into it, members can view plan information, medical and pharmacy benefit information, and key documents and forms. MyCarePlus will continue to evolve, based on member feedback and requests.

INELIGIBLE FOR CAREPLUS MEMBERSHIP

The following categories of individuals are ineligible for membership:

- Individuals who are medically determined to have end-stage renal disease (ESRD) prior to completing the enrollment election
- Individuals enrolled in a PDP cannot be simultaneously enrolled in an MA-PD plan
- Individuals residing outside of CarePlus’ service areas
- Individuals who do not agree to abide by the rules of the plan
- Individuals not enrolled with both Medicare Part A and Part B
- Individuals who are not legal United States residents

IDENTIFYING/VERIFYING CAREPLUS MEMBERS

Upon receipt of the enrollment application, CarePlus sends members a member identification (ID) card and a Verification of Enrollment letter. Once CMS accepts the enrollment, CarePlus then sends members the Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment letter with an evidence of coverage (EOC). The EOC educates members on the following:
• How to schedule an appointment with his/her PCP
• What to do in case of an emergency
• How to contact his/her PCP during and after business hours
• How to access out-of-area services

Each CarePlus member is identified by a CarePlus member ID number which indicates assignment to a specific PCP and copayment guidelines. All CarePlus members are sent an ID card which must be presented at the time of each visit. When membership eligibility cannot be determined, you may contact the provider services queue for eligibility verification at 1-866-313-7587, Monday through Friday from 8 a.m. to 5 p.m.; or verify eligibility online via CarePlus’ Provider Web Services at www.careplus-hp.com/pws.htm, or using Availity (www.availity.com) and/or Change Healthcare (formerly Emdeon) (http://changehealthcare.com).

Please note that possession of an ID card does not constitute eligibility for coverage. Therefore, it is important that physicians/providers verify a member’s eligibility each time the member presents at the office for services. If a CarePlus member is unable to present his/her membership card, please call the provider services queue to determine eligibility. Members cannot be denied medical services.

Verifying eligibility does not guarantee that the member is in fact eligible at the time the services are rendered or that payment will be issued. Payments will be made for the specific covered services provided to eligible CarePlus members after satisfaction of applicable premiums and co-payments.

IDENTIFYING/VERIFYING CAREPLUS MEMBERS’ MEDICAID ELIGIBILITY

The state of Florida recognizes QMB, QMB+, SLMB+ and other FBDEs as cost-share protected individuals. Providers must not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any of these individuals. Providers may verify a member’s Medicaid eligibility using Availity (www.availity.com) or PWS (www.careplus-hp.com/pws.htm). In addition, a cost-share protected indicator can be found on a member’s ID card (see example below).
For additional information regarding the QMB program and billing practices, as it relates to cost-share protected individuals, please refer to the following CMS Medicare Learning Network (MLN) Matters® article: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMatters Articles/downloads/SE1128.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMatters Articles/downloads/SE1128.pdf)
Enrollment Options

- Enroll in a Medicare Advantage plan that has prescription drug coverage (MAPD)

There are six types of election periods during which individuals may make enrollment changes for MAPD plans:

- The Annual Election Period (AEP)
- The Initial Coverage Election Period (ICEP)
- Initial Enrollment Period for Part D (IEP for Part D. For MA, allows enrollment requests for MA-PD plans only)
- The Open Enrollment Period for Institutionalized Individuals (OEPI)
- All Special Election Periods (SEP)
- The Medicare Advantage Open Enrollment Period (MA OEP)

People who are new to Medicare have an Initial Coverage Election Period (ICEP) that is similar to the Initial Enrollment Period for Part B. This period begins three months immediately before the individual’s first entitlement to both Medicare Part A and Part B and ends on the later of 1) the last day of the month preceding entitlement to both Part A and Part B, or 2) The last day of the individual’s Part B initial enrollment period. Once an ICEP enrollment request is made and enrollment takes effect, the ICEP election has been used.

The AEP is Oct. 15 through Dec. 7 of every year. During the AEP, MA-eligible individuals may enroll in or disenroll from an MA plan. Changes made would take effect Jan. 1 of the following year.

The MA OEP is Jan. 1 through March 31 of every year for individuals enrolled in an MA plan as of Jan. 1. During the MA OEP, MA plan enrollees may switch to a different MA plan (with or without Medicare prescription drug coverage) or return to Original Medicare (with or without Medicare prescription drug coverage). For new Medicare beneficiaries enrolled in an MAPD plan during their ICEP, the MA OEP is from the month of entitlement to Part A and Part B through the last day of the third month of entitlement.

Special Enrollment Periods (SEPs)
Special enrollment periods (SEP) constitute periods outside of the usual ICEP, AEP or MA OEP when an individual may elect a plan or change his or her current plan election. Below is a listing of the various types of SEPs:

- Change in residence
- MA contract violation
- MA nonrenewal or terminations
- SEPs for exceptional conditions
  - Employer/group health plan
  - Individuals who disenroll in connection with a CMS sanction
  - Individuals enrolled in cost plans that are not renewing their contracts
  - Individuals in the Program of All-Inclusive Care for the Elderly (PACE)
  - Individuals who dropped a Medigap policy when they enrolled for the first time in an MA plan, and who are still in a trial period
Individuals with ESRD whose entitlement determination is made retroactively
- Individuals whose Medicare entitlement determination is made retroactively
- MA SEPs to coordinate with Part D enrollment periods
- Individuals who have an involuntary loss of creditable coverage, not including a loss due to failure to pay plan premiums
- Individuals who lose special needs status
- Individuals who belong to a qualified state pharmaceutical assistance program (SPAP) or lose SPAP eligibility
- Non-U.S. citizens who become lawfully present
- Individuals who gain, lose or have a change in their dual or LIS eligible status
- Disenrollment from Part D to enroll in or maintain other creditable coverage
- Enrollment in an MA plan or PDP with a plan performance rating of five stars*
- Individuals who requested materials in accessible formats but CarePlus or CMS was unable to provide required notices/information in a timely manner (to allow for equal time to make enrollment decisions
- Individuals affected by a FEMA-declared weather related emergency or major disaster

- SEPs for beneficiaries age 65
- Significant change in provider network

Note: Without evidence of other creditable coverage, individuals who become eligible for Medicare and choose not to enroll in a prescription drug plan at that time will likely pay a penalty if they choose to enroll later. This is known as a late enrollment penalty.

Sample Member Identification (ID) Card (enlarged for better visibility):

MEDICAL RECORDS:

Well-documented medical records are fundamental to maintaining and enhancing coordination and continuity of care, facilitating communication and promoting quality care. CarePlus requires all participating providers to maintain individual, appropriate, accurate, complete and timely medical records for all CarePlus members receiving medical services. Medical records must be in a format required by Medicare laws, regulations, reporting requirements, CMS and CarePlus instructions and maintained for a minimum of 11 years. Medical records must be available for utilization, risk management, peer review, studies, customer service inquiries, grievance and appeals processing, validation of risk adjustment data and other initiatives CarePlus may be required to conduct. To comply with accreditation and regulatory
requirements, periodically CarePlus may perform a medical record documentation audit of some provider medical records. Please refer to section **Medical Record Documentation Standards** for additional details pertaining to medical record documentation.

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of member information.

Facilities are also expected to establish policies that are consistent with the following:

- Maintain a system for the collection, processing, maintenance, storage, retrieval, and distribution of members’ medical records. Designate a person in the office to be responsible for this system. This person is responsible for the overall maintenance of the provider’s medical records and specifically for:
  - Maintaining confidentiality, security, and physical safety of the records
  - The timely retrieval of individual records upon request
  - The unique identification of each member's record
  - The supervision of the collection, processing, maintenance, storage, and appropriate access to (e.g., retrieval) and usage of records (e.g., distribution)
  - The maintenance of a predetermined, organized and secured record format
  - The release of information contained in records in compliance with state and federal requirements governing the release of medical information

- Policies address retention of active records, inactive records and timely entry of data in records
- Ensuring medical records are filed away from public access

**ADVANCE DIRECTIVES:**

CarePlus acknowledges a member’s right to make an advance directive. Advance directives are written instructions, such as living wills or durable power of attorney for healthcare, recognized under state law and signed by a member, that explain the member’s wishes concerning the provisions of healthcare should the member become incapacitated and is unable to make those wishes known.

Providers are expected to advise all CarePlus members regarding his or her future healthcare needs and available options. Providers may give advance directive information to the member’s family or surrogate should the member be incapacitated at the time of enrollment.

Providers should:

- On the first visit and during routine office visits when appropriate, discuss the member’s wishes regarding advance directives for care and treatment
- If asked, provide the member with information about advance directives
- Document in a prominent part of the member’s current medical records whether the individual has executed or refused an advance directive
- Not discriminate against the member based on whether he or she has executed an advance directive

CarePlus is pleased to have available printed versions of **Five Wishes®** booklets with permission from Aging with Dignity. This document was designed by the Commission on Aging with Dignity and it meets
Florida legal requirements for advance directives. Five Wishes is easy to understand and will allow your patients to express how they want to be treated if they are seriously ill and unable to speak for themselves. If you would like to receive hard copies of this document, please contact your assigned provider services executive or call the Provider Operations inquiry line at 1-866-220-5448, Monday through Friday from 8 a.m. to 5 p.m.

Advance directive forms also are available at the National Hospice and Palliative Care Organization' (NHPCO) Caring Connections website: http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3284.

**EMERGENCY AND DISASTER PREPAREDNESS PLAN:**

Facilities are expected to have a comprehensive, written emergency and disaster preparedness plan to address internal and external emergencies, including participating in community health emergency or disaster preparedness, when applicable. The written plan must include a provision for the safe evacuation of individuals during an emergency, especially individuals who may be unable to self-evacuate. For your convenience, we have included a sample of an emergency evacuation plan at the end of this manual.

In the event a disaster or other crisis requires evacuation from your geographic area and/or relocation of your provider office(s), you must complete the Provider Crisis Contact/Location Information Form located in the **Forms** section of this manual. This form also is available on the CarePlus website at https://www.careplushealthplans.com/careplus-providers/updates under Provider Crisis Contact/Location Information. This form is needed so that the CarePlus Member Services department will have the most current information to provide to our members who may call for assistance in locating their providers during emergency situations. The Provider Crisis Contact/Location Information Form may be submitted to CarePlus’ Provider Operations department in any of the following ways:

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<tr>
<th>Mail</th>
<th>Fax</th>
<th>Provider Services Executive</th>
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<tr>
<td>Attention: Provider Operations Dept.  11430 NW 20th St, Suite 300  Miami, FL 33172</td>
<td>786-336-8674</td>
<td>Please scan the form and email it directly to your assigned provider services executive</td>
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In addition, you may also contact CarePlus’ Provider Emergency Hotline at 1-877-210-5318. The purpose of this hotline is to give our provider community instructions and information with regards to CarePlus and its members in the event that CarePlus is forced to close as a result of natural disaster.

**INFECTION CONTROL AND PREVENTION AND SAFETY IN A FACILITY SETTING:**

Facilities of all sizes are expected to have in place the policies and tools necessary to ensure their sites are operated in a safe, sanitary and secure manner. Your facility must be in compliance with federal and state regulations concerning infection control (e.g., prevention, control, identification, reporting), exposure to bloodborne pathogens and the use of universal precautions. It is strongly recommended that you implement measures and processes in accordance with nationally recognized standards and organizations.

- **Infection Control and Prevention**

  Wherever patient care is provided, application and adherence to infection control and prevention guidelines are needed to ensure that all care is safe and provided in a functional and sanitary
environment. Today, healthcare is delivered in a variety of settings where with each encounter (e.g., patient-to-patient, patient-to-physician, or patient to staff member) there is an opportunity for infection or transmission prevention. It is your responsibility to minimize the risk of acquiring an infection in your facility.

All contracted facilities are expected to have written policies for infection control and prevention that are readily available, updated annually and enforced. All patients and personnel should be educated regarding the various modes infections may be transmitted (e.g., directly or indirectly) and the techniques that can prevent or minimize the risk of transmission. The Centers for Disease Control and Prevention (CDC) provide standards and guidelines that are appropriate for most patient encounters. Furthermore, the Occupational Safety and Health Administration (OSHA) require facilities as employers to have processes in place to reduce the risk of their employees from being exposed to bloodborne pathogens or other potentially infectious materials.

Key principles of infection control include, but may not be limited to, the following:

- Hand hygiene consistent with nationally recognized guidelines (i.e., WHO, CDC, etc.)
- Written bloodborne pathogen exposure control plan
- Personal protective equipment (PPE) such as gloves, eyewear, facial masks or gowns
- Immunization of personnel (e.g., hepatitis B, tuberculosis, etc.)
- Monitoring of employee illnesses
- Safe handling and disposal of needles and sharp containers
- General housekeeping policies – cleaning, disinfection, antisepsis and sterilization of medical equipment and patient areas (e.g., examination rooms should be cleaned before and after each patient, and along with patient waiting areas, should be thoroughly cleaned at the end of each day)
- Appropriate hazardous waste disposal policies
- Isolation or immediate transfer of individuals (patients and staff members) with an infectious or communicable disease
- Processes to communicate with local and state health authorities (e.g., reporting of communicable or infectious diseases)
- Processes that address the recall of items including drugs and vaccines, blood and blood products and medical devices or equipment
- Recordkeeping
- Employee orientation and annual staff training regarding office procedures, plans and programs (e.g., OSHA, infection control/prevention, sharps injury prevention, bloodborne pathogens)

Listed below are resources to assist you and your staff in locating guidelines or best practices to reduce the day-to-day risks of transmission in your facility. Please note that additional resources are available on the CarePlus website on the “Information for Providers” webpage at https://www.careplushealthplans.com/careplus-providers/updates.

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<td>CDC</td>
<td>Healthcare-associated Infections (HAIs) Guidelines, <a href="https://www.cdc.gov/infectioncontrol/guidelines/index.html">https://www.cdc.gov/infectioncontrol/guidelines/index.html</a></td>
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<td>Agency</td>
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<td>CDC</td>
<td>Healthcare-associated Infections (HAIs) Guide to Infection Prevention for</td>
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<td>Outpatient Settings – Minimum Expectations for Safe Care,</td>
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<td>CDC</td>
<td>2007 Guidelines for Isolation Precautions: Preventing Transmissions of</td>
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<td>Infectious Agents in Healthcare Settings,</td>
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<td>CDC</td>
<td>Hand Hygiene in Healthcare Settings, <a href="www.cdc.gov/handhygiene">www.cdc.gov/handhygiene</a></td>
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<td>CDC</td>
<td>Injection Safety, <a href="www.cdc.gov/injectionsafety">www.cdc.gov/injectionsafety</a></td>
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<td>OSHA</td>
<td>Medical and Dental Offices – A Guide to Compliance with OSHA Standards,</td>
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<td>OSHA</td>
<td>Safety and Health Topics: Healthcare – Standards/Enforcement,</td>
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<td>OSHA</td>
<td>Safety and Health Topics: Healthcare – Other Hazards,</td>
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<td>OSHA</td>
<td>Safety and Health Topics: Bloodborne Pathogens and Needlestick Prevention</td>
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<td>OSHA Publication</td>
<td>Model Plans and Programs for the OSHA Bloodborne Pathogens and Hazard</td>
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<td>Communications Standards (OSHA 3186-06R 2033), <a href="www.osha.gov/Publications/osha3186.pdf">www.osha.gov/Publications/osha3186.pdf</a></td>
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<tr>
<td>CDC</td>
<td>Guideline for Disinfection and Sterilization in Healthcare Facilities,</td>
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<td><a href="https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html">https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html</a></td>
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<tr>
<td>U.S. Food and Drug Administration (FDA)</td>
<td>Guidance for Industry and FDA Staff – Medical Device User Fee and</td>
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<td>Modernization Act of 2002, Validation Data in Premarket Notification</td>
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<td>Submissions (510(k)s) for Reprocessed Single-Use Medical Devices,</td>
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### Safety

A comprehensive safety program should be established to address the facility’s environment of care and the safety for all your patients. The elements of the safety program should include, but not be limited to the following:

- Processes for the management of identified hazards, potential threats, near misses and other safety concerns
- Processes for reporting known adverse incidents to appropriate local, state and/or federal agencies when required by law to do so
- Unique patient identifiers are used throughout care
- Processes to reduce and avoid medication errors. Examples of such are:
  - Write legible prescriptions which include dosage and indication
  - Utilize an electronic prescribing system and submit electronic requests directly to pharmacies
Encourage and educate members to be actively involved in their healthcare and serve as safety checkers. Members should review their medications prior to taking them and when picking up medications from the pharmacies.

- Policies addressing manufacturer or regulatory agency recalls related to medications, medical equipment and supplies and which include: (i) sources of recall information (e.g., FDA, CDC); (ii) methods to notify staff that need to know; (iii) methods to determine if a recalled product is present at the facility or has been given or administered to a member; (iv) documentation of response to recalled products; (v) disposition or return of recalled items (including samples) and (vi) member notification*, as appropriate.

*When notified of a drug recall, CarePlus utilizes pharmacy claims data to identify members who have received the recalled medication. CarePlus provides prompt notification to the impacted members and their prescribing physicians.

- Policies regarding food and drink, if made available
- Establish a process to ensure that all tests ordered are received
- Environmental hazards associated with safety are identified (i.e., fall prevention, physical safety, ergonomic exposures, violence in the workplace and external physical threats) and safe practices are established

It is important to always remember that safety policies and procedures help achieve a safer work environment and improve the quality and effectiveness of the care you provide to your patients.

**SITE VISITS – FACILITIES AND ENVIRONMENT**

CarePlus conducts site visits to assess the office environment as it relates to physical accessibility, physical appearance, adequacy of patient care areas and medical equipment, medical record policies and practice management. A site visit may be conducted upon initial credentialing and on other occasions as determined by CarePlus (e.g., quality review).

CarePlus’ site visit standards are based on state and federal guidelines, as well as accreditation standards established by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

The standards reviewed during site visits include, but may not be limited to, the following:

**A. Accessibility/Physical Appearance**

1. Site is operated in a safe and secure manner
2. Provides reception areas, toilets, and telephones in accordance with patient/visitor volume
3. Adequately marked patient/visitor parking, when appropriate
4. Examination rooms, dressing rooms, and reception areas are constructed and maintained in a manner that ensures patient privacy
5. Provisions are made to reasonably accommodate disabled individuals
6. Adequate lighting and ventilation are provided in all areas
7. Office/facility is clean and properly maintained
8. Space allocated for a particular function or service is adequate for the activities performed therein
9. Smoking is prohibited in the office/facility
10. Office/facility must be in compliance with applicable state and local building codes and regulations; state and local fire prevention regulations; applicable federal regulation and receive periodic inspection by local or state fire control agency, if this service is available in the community

**Note:** In the event an office/facility undergoes demolition, construction or renovation projects, providers are expected to conduct a proactive and ongoing risk assessment for existing or potential environmental hazards.

**B. Medical Records and Confidentiality**

1. Medical recordkeeping practices (e.g., unique identification of each member’s records, timely retrieval of requested medical records, secured and filed away from public access)
2. Documentation in medical records, to include advance directives
3. Policies addressing retention, maintenance, storage, retrieval and distribution of medical records

**C. Fire Safety**

1. Appropriately maintained and placed fire-fighting equipment to control a limited fire for each potential type of fire (e.g., ABC fire extinguisher)
2. Prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall
3. Emergency lighting, as appropriate, to provide adequate illumination for evacuation of patients and staff in case of an emergency
4. Testing of fire alarm and inspection of fire suppression systems, if applicable
5. Stairwells are protected by fire doors, if applicable

**D. Emergency and Disaster Preparedness**

1. Office/facility has the necessary personnel, equipment and procedures to deliver safe care, and to handle medical and other emergencies that may arise
2. Documented periodic instruction of all personnel in the proper use of safety, emergency and fire-extinguishing equipment
3. Conduct at least one drill a year of the internal emergency and disaster preparedness plan as appropriate to the office/facility. A written evaluation of the drill must be completed to promptly implement any needed corrections or modifications to the plan
4. Personnel trained in CPR and the use of cardiac and all other emergency equipment are present in the office/facility to provide patient care during hours of operation
5. Alternate power, adequate for the protection of the life and safety of patients and staff, is available in all patient care areas
6. Appropriate emergency equipment and supplies are maintained and are readily accessible to all areas of patient care

**E. Safety**

1. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are eliminated
2. Food services and refreshments provided to patients meet their clinical needs and are prepared, stored, served and disposed of in compliance with local, state and federal health department requirements, if applicable.

3. A system exists for the proper identification, management, storage, handling, transport, treatment and disposal of hazardous materials and wastes, whether solid, liquid or gas. The system includes, but is not limited to: (i) infectious, radioactive, chemical and physical hazards; and (ii) provides for the protection of patients, staff and the environment.

4. Policies and procedures regarding medical equipment include its standardized use and documented evidence of periodic testing and scheduled preventive maintenance according to manufacturer’s specifications.

5. Ongoing monitoring of expiration dates for medications (including samples)

6. Ongoing temperature monitoring of refrigerated medications (including samples)

7. Medications (including samples) are stored in a secured location

**MEMBER DISENROLLMENT PROCEDURE:**

A member may disenroll from CarePlus only during a valid election period. Some members may have special circumstances. For disenrollment procedures, please refer members to the member services department for assistance at 1-800-794-5907.

**INVolUNTARY DISENROLLMENT**

Disenrollment may be involuntary under the following conditions:

- Death of member
- Loss of Medicare entitlement to Part A and/or Part B
- Disruptive behavior to the extent that a member’s continued enrollment in CarePlus substantially impairs CarePlus’ ability to arrange for or provide services to either that particular member or other members of the plan. Disruptive behavior must be substantiated by strong evidence.
- CarePlus’ contract is terminated or CarePlus reduces its service area to exclude the member.
- Member permanently moves outside the service area, is away from the service area for more than six consecutive months or is incarcerated and, therefore, out of the area.
- Unlawful presence status in the United States
- Member provides fraudulent information on an election form or permits fraudulent use of the member identification (ID) card
- Member is no longer eligible for plan (e.g., SNP plans)
- Member fails to pay their Part D Income-related Monthly Adjustment Amount (IRMAA) to the government and CMS notifies the plan to effectuate the disenrollment

If a member’s behavior is so disruptive that it substantially impairs CarePlus’ ability to arrange for the care of that member or other members of the plan, CarePlus may submit a request to CMS to have the member involuntarily disenrolled from the plan.

Requests cannot be made as a result of a member exercising the option to make treatment decisions with which the plan disagrees, including the option of no treatment and/or no diagnostic testing. CarePlus cannot disenroll a member because he/she chooses not to comply with any treatment regimen (CFR 42 §422.74).
Serious effort to resolve the problems presented by the member must be made. Such efforts must include providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities.

A PCP may request an involuntary disenrollment of a CarePlus member for cause. The required information includes, but is not limited to, the following:

- Details of disruptive behavior, including a thorough explanation detailing how the member’s behavior has impacted the PCP’s or CarePlus’ ability to arrange for or provide services to the member
- Member information, including age, diagnosis, mental status, functional status, description of their social support systems and any other relevant information
- Statement(s) from the PCP describing his/her experience with the member
- Efforts to resolve the problem
- Efforts to provide reasonable accommodations for members with disabilities, in accordance with the Americans with Disabilities Act
- Evidence indicating that the member’s behavior is not related to the use/lack of use of medical services
- Evidence of appropriate written notices addressed to the member and/or information provided by the member

The disenrollment for disruptive behavior process requires three written notices:

1. Advance notice to inform the member that the consequence of continued disruptive behavior will be disenrollment
2. Notice of intent to request CMS’ permission to disenroll the member
3. A planned action notice advising that CMS has approved the MA organization’s request

In situations where CarePlus disenrolls the member involuntarily for any of the reasons addressed above, CarePlus must send the member or his authorized representative notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that CarePlus intends to disenroll the member and why such action is occurring
- Provides the effective date of termination
- Includes an explanation of the member’s grievance rights

Unless otherwise indicated, all notices must be mailed to the member before submission of the disenrollment transaction to CMS.

**CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) UPDATES AND EDUCATIONAL RESOURCES:**

CMS issues program transmittals to communicate new or changed policies, and/or procedures that are being incorporated into a specific CMS program manual. The cover page (or transmittal) summarizes the new material, specifying the changes made. Furthermore, CMS has developed MLN Matters® which provides Medicare coverage and reimbursement rules in a brief, accurate and easy-to-understand format.
It’s important that you remain up-to-date on all regulatory changes as it is your responsibility to implement any applicable changes. To find specific CMS transmittals or MLN Matters® articles, please visit the CMS website at the following addresses:


**CMS LOCAL COVERAGE GUIDELINES (LCDs) AND NATIONAL COVERAGE DETERMINATIONS (NCDs)**

Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury and within the scope of a Medicare benefit category. National coverage determinations (NCDs) and local coverage guidelines (LCDs) describe whether specific medical items, services, treatment procedures, or technologies can be paid under Medicare. It’s important that you remain up-to-date on these changes to coverage. Helpful resources include:

CMS Medicare Coverage Center: [https://www.cms.gov/center/coverage.asp](https://www.cms.gov/center/coverage.asp)

Note: CarePlus provides direct access to the above-mentioned CMS websites on our CarePlus website at: [https://www.careplushealthplans.com/careplus-providers/updates](https://www.careplushealthplans.com/careplus-providers/updates) under the section of “CMS Transmittals and National Coverage Determinations.”
Before terminating a contract with a physician/provider, a written explanation of the reason(s) must be provided. Notice is given to the physician/provider at least 60 days before the termination date, without cause as stipulated in the physician agreement. Nonetheless, CarePlus may immediately suspend or terminate a provider under circumstances including, but not limited to, the following:

- Termination, suspension, limitation, voluntary surrender or restriction of professional license or other government certification/licensure
- Conviction of a felony or any other criminal charge
- Any disciplinary action taken by the Drug Enforcement Agency (DEA)
- Any other legal, government or other action or event which may materially impair the ability to perform any duties or obligations under the provider’s agreement with CarePlus

Individual physicians/provider, who participate in CarePlus’ network and are terminated by CarePlus, may be entitled to an advisory panel review of their termination.

A physician who terminates or has been terminated from the plan for any reason, except for violations of medical competence or professional behavior, may request that a patient who is currently under treatment continue to receive care for a limited time or to arrange for the patient’s transfer to another physician or provider.

**Note:** Provider will provide or arrange for continued treatment until the member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the member’s course of treatment, or until plan has made arrangements for substitute care for the member; and (ii) until the date of discharge for members hospitalized on the effective date of termination of the agreement. Members will be given reasonable advance notice of the impending termination of any provider. Continuity of care determinations will be made on a case-by-case basis by the plan.

CarePlus reviews the Department of Health and Human Services’ (HHS) and the Office of the Inspector General’s (OIG) exclusion lists as often as required by federal regulations. If your name appears in the current OIG’s excluded/sanctioned provider listing, your contract with CarePlus will be immediately terminated. If you have been reinstated into a federal healthcare program(s), contact CarePlus immediately.
Medicare beneficiaries who are hospital inpatients have a statutory right to appeal to the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for an expedited review when a hospital with physician concurrence, determines that inpatient care is no longer necessary.

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals must use the “Important Message from Medicare” (IM), a statutorily required notice, to explain the beneficiary’s rights as a hospital patient, including discharge appeal rights. The IM is available in English and Spanish, and in PDF and Word format by CMS (see the link at the end of this section). Hospitals should utilize the appropriate version of the IM based on the language the beneficiary best understands.

Hospitals must issue the IM within two calendar days of the admission, must obtain the signature of the beneficiary or his/her representative, and provide a copy at that time. Hospitals also will deliver a copy of the signed notice as far in advance of discharge as possible, but no more than two calendar days before discharge. However, when discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge, if necessary, giving the member at least four hours to consider their right to request a BFCC-QIO review. If the hospital delivers the follow-up notice and the status subsequently changes, so that the discharge is beyond the two-day timeframe, hospitals must deliver another copy of the signed notice again within two calendar days of the new planned discharge date. Hospitals may NOT develop procedures for delivery of the follow up copy routinely on the day of discharge.

Regardless of the competency of the Medicare beneficiary, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him/her of the beneficiary’s right as a hospital patient, including the right to appeal the discharge decision. The date the hospital conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice. Additionally, the telephone contact should be confirmed by a written notice mailed on that same date as the telephone contact. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested, or other delivery method that requires signed verification of delivery. The date that someone at the representative’s address signs (or refuses to sign) the receipt is the date received. If both the hospital and the representative agree, hospitals may send the notice by fax or email; however, hospitals must meet HIPAA privacy and security requirements.

**Note:** Beneficiaries who are being transferred from one inpatient hospital setting to another inpatient hospital setting, do not need to be provided with the follow-up copy of the IM notice prior to leaving the original hospital, since this is still considered to be the same level of care. Medicare beneficiaries always have the right to refuse care and may contact the BFCC-QIO if they have a quality of care issue. The receiving hospital must deliver the IM notice from Medicare according to the procedures in these instructions.

Hospitals must place dated copies of the initial IM notice and any subsequent follow up notices in the beneficiary’s medical file, and document all telephone conversations with the beneficiary’s representative (if applicable). Hospitals must demonstrate compliance with this process.

Medicare beneficiaries have until midnight of the day of discharge to make a timely request to the BFCC-QIO. The beneficiary is not financially responsible (except applicable coinsurance or deductible) furnished before noon of the calendar day after the date the beneficiary receives notification from the
BFCC-QIO. Liability for further inpatient hospital services depends on the BFCC-QIO. The BFCC-QIO will notify CarePlus that the beneficiary has filed a request for immediate review (appeal). CarePlus and/or hospitals must provide the BFCC-QIO with all the necessary information by telephone or in writing at the BFCC-QIO’s discretion.

- If the BFCC-QIO agrees with the plan/hospital, the BFCC-QIO will notify the beneficiary and liability for continued services begins at noon of the day after the BFCC-QIO notifies the beneficiary, or as determined by the BFCC-QIO.
- If the BFCC-QIO agrees with the beneficiary, the BFCC-QIO notifies the beneficiary and advises the beneficiary of not having financial liability for continued stay other than applicable coinsurance or deductible. A follow up copy of the IM will need to be delivered once discharge is once again determined.

For additional information regarding Hospital Discharge Appeal Process and Notices, please visit the CMS website at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html).
On Aug. 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospital and critical access hospitals (CAHs) to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatient for more than 24 hours. All hospitals and CAHs were required to begin using the MOON notification no later than March 8, 2017 and thereafter.

The Medicare Outpatient Observation Notice (MOON) was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH. In accordance with the statute, the notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted.

**Notice Instructions: Medicare Outpatient Observation Notice**

**Page 1 of the Medicare Outpatient Observation Notice (MOON)**

The following blanks must be completed by the hospital. Information inserted may be typed or legibly hand-written in 12-point font or the equivalent.

**Patient Name:** Fill in the patient’s full name or attach patient label.

**Patient ID number:** Fill in an ID number that identifies this patient, such as a medical record number or the patient’s birthdate or attach a patient label. This number should not be the patient’s social security number.

“**You’re a hospital outpatient receiving observation services. You are not an inpatient because**”: Fill in the specific reason the patient is in an outpatient, rather than an inpatient stay.

**Page 2 of the MOON**

**Additional Information:** This may include, but is not limited to, Accountable Care Organization (ACO) information, notation that a beneficiary refused to sign the notice, hospital waivers of the beneficiary’s responsibility for the cost of self-administered drugs, Part A cost sharing responsibilities if the beneficiary is subsequently admitted as an inpatient, physician name, specific information for contacting hospital staff, or additional information that may be required under applicable state law.

Hospitals may attach additional pages to this notice if more space is needed for this section.

**Oral Explanation:** When delivering the MOON, hospitals and CAHs are required to explain the notice and its content, document that an oral explanation was provided and answer all beneficiary questions to the best of their ability.

**Signature of Patient or Representative:** Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents. If a representative’s signature is not legible, print the representative’s name by the signature.
Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Information on the MOON including a copy of the English and Spanish forms and additional instructions may be found at the CMS website at: [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html)
NOTICE OF MEDICARE NON-COVERAGE (NOMNC) FOR A SKILLED NURSING FACILITY (SNF) STAY FACT SHEET

The Centers for Medicare & Medicaid Services (CMS) requires that members enrolled in a Medicare Advantage (MA) health plan, have the right to an expedited review by a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), in Florida, KEPRO, when they disagree with the decision that their services from a SNF should end.

The NOMNC document is to be issued for every discharge no later than two days in advance of the services ending. The NOMNC document informs the patient the date coverage of services ends, and describes the member appeal process.

WHAT YOU MUST DO

- Provide a current NOMNC document to CarePlus beneficiaries or authorized representative and obtain their signature on the form (refer to the “Who Must Sign” below for guidance).
- Fax a copy of the signed and dated document to CarePlus to 1-866-229-1538 and keep a copy in the patient’s medical record as required by CMS.
- The effective date or “services will end” date is considered the last full day of coverage (effective date of coverage termination).

NOMNC DOCUMENT PROCESS

- The NOMNC is a standardized notice. Therefore, plans and providers may not re-write, re-interpret or insert non-OMB-approved language into the body of the notice except where indicated. The CMS form number and the OMB control number must be displayed on the notice.
- The document must be properly completed by the SNF and include the facility name, full address, 10 digit phone and fax numbers as the header. Do not use CarePlus’ information as header.
- The document must be signed and a copy faxed to CarePlus at 1-866-229-1538 no later than two days before a patient’s coverage of services from your facility is due to terminate.
- The document must include the name and telephone numbers (including TTY) of the applicable BFCC-QIO, as shown below.
  
  KEPRO  
  Telephone: 1-888-317-0751  
  TTY: 1-855-843-4776 to appeal.
- The document must include CarePlus’ name and contact information, as shown below, for the enrollees use in case an expedited appeal is requested or in the event the enrollee or BFCC-QIO seeks the plan’s identification.
  
  CarePlus Health Plans Inc.  
  11430 NW 20th St., Suite 300  
  Miami, FL 33172  
  Telephone: 1-800-794-5907  
  TTY: 711  
  Fax: 1-800-956-4288
- If services are expected to be less than two days, deliver the notice upon admission.
- The document must be signed by the beneficiary or designated representative, or in absence of a signature, the document must note the said person who was presented with the document.
including date, time, name of person, relationship, contact phone number. The documentation will indicate that the staff person told the representative the date the patient’s financial liability begins, the QIO phone number, the patient’s appeal rights, and how and when to initiate an appeal. Also include the name, organization and contact number of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. (Include in the middle of Page 2 of the document under “Additional Information (Optional).” Refer to the Who Must Sign section of this facility manual (below) for more details.

- If the patient chooses to appeal, he or she must contact the KEPRO to request a review no later than noon on the day before services are to end. The KEPRO appeal decision generally be completed within 48 hours of the patient’s request for a review.
- The facility must provide all appropriate medical records to the KEPRO via fax at 1-833-868-4058 by the end of business day on the same day the records are requested by the KEPRO or by the timeframe noted on the KEPRO Request for Medical Record form. This applies seven days a week, including weekends and holidays. Records can include but not limited to: evaluations and therapy notes, physician progress notes, physician’s orders, nurse’s notes, medication records, and any other pertinent information from admission date through the date of appeal. CarePlus is required to issue a Detailed Explanation of Non-coverage (DENC) to the patient and provide a copy to the KEPRO and the SNF to deliver to the beneficiary or the representative no later than close of business the day the KEPRO’s notification that the patient requested an appeal is issued or the day before coverage ends, whichever is less. The intent of the requirement that the beneficiary or representative receive the DENC is to make sure that those who choose to appeal are made aware of the reasoning for the coverage termination and have an opportunity to present their views to the KEPRO.
- Failure to comply exactly with this process will result in non-payment of days for facility-related delays.

Where to find current NOMNC Document (Form CMS 10123-NOMNC)

- The English version of the NOMNC can be found under the Forms section of this document; if you need a Spanish version of the NOMNC, please reach out to your CarePlus Provider Services executive.
- CMS instructions on the NOMNC can be found at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html. Select the “Instructions for Notice of Medicare Non-Coverage” PDF under the downloads section.

Where to find additional information

- CMS requirement 42 CFR 422.624(b) (2) can be found as a final rule published in the April 4, 2003, edition of the Federal Register, Vol. 68, No. 16652.
- Contact the CarePlus field care manager for your facility if you have additional questions.

Sample of SNF Appeal Scenario

CarePlus authorizes Jane Doe to receive care from a SNF from May 25 through June 4. The NOMNC is delivered to Ms. Doe on June 2, to advise that the SNF services are scheduled to terminate on June 4. Ms. Doe feels she needs additional services and decides to appeal.
**WHO MUST SIGN**  

- Beneficiaries (or their authorized representative) whose coverage for services will end. The beneficiary must be able to understand that he/she may appeal the decision. If a patient is able to comprehend the notice, but is either physically unable to sign, or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting the use of such assistance. Furthermore, if the patient refuses to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the patient refused to sign including date, time, name, relationship, and contact phone number. The documentation will indicate that the staff person told the representative the date the patient’s financial liability begins, the QIO phone number, the patient’s appeal rights, and how and when to initiate an appeal. Also include the name, organization and contact number of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. (Include in the middle of Page 2 of the NOMNC, “Additional Information (Comments).”

- **If the beneficiary is not able to comprehend the contents of the notice,** it must be delivered to and signed by the patient’s representative. If the representative is not available to receive and sign the notice, they must be contacted by telephone to advise him/her when the patient’s services will no
longer be covered. The facility must identify itself to the representative and provide a contact number for questions about the discharge plan. It must describe the purpose of the call which is to inform the representative about the right to file an appeal. The information provided must, at a minimum, include the following:

- The date services end, and when the patient’s liability begins. The date services will end is the same as the discharge date
- How to get a copy of a detailed notice describing why the patient’s services are not being provided
- A description of the particular appeal right being discussed (e.g., BFCC-QIO vs. expedited);
- When (by what time/date) the appeal must be filed to take advantage of the particular appeal right
- The entity required to receive the appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires in order to receive the appeal in a timely fashion
- Provide at least one telephone number of an advocacy organization, or 1-800-MEDICARE, that can provide additional assistance to the representative in further explaining and filing the appeal
- Additional documentation that confirms whether the representative, in the writer’s opinion, understood the information provided

The date the facility conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice. Place a dated copy of the notice in the patient’s medical file, and document the telephone contact with the member’s representative (as listed above) on the notice itself (middle of Page 2, “Additional Information (Comments),” and in a separate entry in the patient’s file or attachment to the notice.

The documentation will indicate that the staff person told the representative the date the patient’s financial liability begins, the QIO phone number, the patient’s appeal rights, and how and when to initiate an appeal. Also include the name, organization and contact number of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

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CarePlus’ Health Service department (HSD) is designed to actively manage and oversee the utilization of healthcare resources while maintaining a high quality of patient care. The program identifies, documents and reviews all utilization of services; including the over and underutilization of medically necessary services. When indicated, corrective action plans will be developed and implemented, to ensure the delivery of medically necessary, appropriate cost-effective, and quality healthcare services are delivered.

**IMPORTANT:** CarePlus requires authorization for all observation status and inpatient admissions.

**Elective Admissions**

- When a PCP or specialist identifies the need to schedule a hospital admission, the Referral Request form must be submitted to the CarePlus Pre-Cert department at least five days prior to the scheduled admission date.
- PCP will notify CarePlus Pre-cert department of his/her intent to admit, as soon as the admission is scheduled and will complete a pre-certification request form, including all supporting medical information, diagnosis codes, and procedure codes for a determination to be made. The hospital must notify CarePlus within 24 hours after the admission.
- Verify member eligibility and benefits for specific service.
- Evaluate the medical necessity and appropriateness of services.
- CarePlus utilizes the following medical guideline criteria for medical determinations: Medicare Local and National Coverage Guidelines (LCDs and NCDs) MCG (formerly Milliman Care Guidelines) If the elective admission is based on medical necessity and the criteria for medical necessity are met, an authorization is provided to the PCP, requesting physician and the facility that is requesting the admission. Once the member is admitted, concurrent review of the members’ medical records are conducted by the plan to ensure physician documentation supports the need for continued hospital stay.
- If the elective admission does not meet medical necessity criteria or the plan is not able to obtain information, the authorization will not be given until the medical information is received to provide a final determination. An NDMC letter will be provided to the member, including the right to request an appeal with the health plan.

**Admissions via Emergency Room**

- The hospital will be responsible for notification of the PCP, the admitting panel physician group call center listed in the important numbers in the manual (if the PCP does not do his/her own admissions), and CarePlus of the admission. The notification must occur within 24 hours after the admission of the member.
- Member eligibility and benefit coverage will be verified by the plan.
- An authorization number will be provided by the plan in a timely manner.
- Concurrent review of planned and emergent admissions, as well as observation services, either on-site or via telephonic/fax review; will be conducted the next business day following notification of the admission by the utilization management nurse.
• Continued stay reviews to authorize additional days as determined by physician documentation of medical necessity will be conducted by the CarePlus utilization management nurse and reviewed with the plan’s medical director.

• Additionally, if the plan is notified of the admission after the patient is discharged, the medical records along with the claims must be submitted to the CarePlus claims department for their review.

**Inpatient Field Case Management**

A CarePlus utilization management nurse will conduct regular concurrent reviews of the members’ hospital medical records either by on-site review at the hospital facility or by telephonically review to determine the authorization for continued length of stay. The facility will be notified regularly of the continued authorized length of stay.

The CarePlus utilization management nurse will review the physician documentation supporting medical necessity for the services ordered medical information on regular intervals. If the utilization management nurse is on-site at the hospital, he/she will conduct a face to face member assessment and collaborate with the attending physician, the hospital’s case manager/discharge staff, the patient and/or family, and the PCP to discuss any assist with the discharge planning needs. The utilization management nurse will verify that the member and/or family are aware of the member's PCP's contact information. He/she will encourage the patient to make a post-hospitalization follow-up appointment with the PCP. **The PCP or specialist, if appropriate, should ensure the member is seen within three to seven days of discharge, and PCP should schedule any other necessary follow-up care.**

**Discharge Planning**

• The objective of discharge planning is to facilitate an appropriate transition of care and ensure continuity of care.

• CarePlus utilizes a pro-active approach to discharge planning beginning within one business day of the admission notification. The CarePlus utilization management nurse collaborates with the facility case management staff and other healthcare providers, the attending physician, and the member and/or care giver, throughout the hospitalization to assist in eliminating barriers for a safe discharge.

**Procedure**

• The hospital medical records are reviewed, and the patient’s psychosocial, medical history, current treatment plan, and prognosis are assessed to determine the need for post discharge care, including home healthcare, DME, short or long term placement in a skilled nursing facility (SNF), long-term acute care hospital (LTACH), or rehabilitation.

• The attending physician and PCP will be contacted to formulate a discharge plan, and post-discharge healthcare service needs will be continually assessed and re-evaluated throughout the hospital stay.

• The facility is responsible for submitting ALL discharge orders for infusion, HHC, and DME directly to the plan’s provider.

• The facility should submit orders of wound care and ostomy supplies in coordination with the concurrent review staff to the plan.

• Any post discharge follow-up appointment and transportation will be coordinated with the PCP office.
• Once the process is finalized, copies of the authorization for discharge services will be auto-faxed to the PCP.

**Note:** If a hospital determines that an enrollee no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a BFCC-QIO review. However, this should not occur until the hospital has consulted with CarePlus. Hospitals must notify the enrollee that the review has been requested.

**CARE MANAGEMENT PROGRAM**

**Program Philosophy:**

CarePlus is dedicated to providing quality, cost-efficient healthcare programs for its members. All programs are developed using a personal care approach to establish a professional relationship with the member or caregiver. These programs may utilize written educational materials, regular member mailings, telephonic assessments and education, as indicated. Each program will utilize the member’s PCP as the primary point of contact in the management of the member. In addition, an interdisciplinary care team (ICT) will be assigned for those members being care-managed with an individualized care plan developed and implemented.

**Program Goals:**

- To provide patient-centered and comprehensive care management programs for the education and management of members with comorbidities and/or who experience a transition of care.
- To promote the PCP as the key person in helping the member maintain or achieve optimal health.
- To ensure that healthcare services/needs are met throughout the member’s duration of enrollment with plan.

**Care Management:**

All CarePlus members may request to be evaluated for care management services. Members who are identified with complex medical conditions are referred to the care management team to have their needs assessed. These members are encouraged to participate in care management, to ensure they receive education regarding their specific healthcare needs and self-care management. They have direct access to a care manager who can assist them in complying with the prescribed treatment plan. In addition, the CarePlus Care Management Team offers a robust telephonic care management experience for all Dual-eligible members. CarePlus monitors health-related conditions and attempts to provide a holistic care management experience to members to enable them to better understand and self-manage their health.

**Care management services are offered to members who meet one or more of the following:**

- All members who are enrolled in a Special Needs Plan (SNP)
- Members identified through the stratification process, which includes:
  - Medicare data files
  - Behavioral health diagnosis data
  - Utilization (i.e. hospital admissions, ER visits, readmissions, etc.)
  - Pharmacy data
  - Predictive modeling
  - Claims data
- Health risk assessment (HRA) data
  - Members referred by their PCP or other healthcare provider
  - Members referred by the CarePlus Field Case Manager

Care management services include

- Medical care management
- Interdisciplinary team meetings
- Individualized care plans
- Post-discharge transition of care follow-up
- Chronic wound care program
- Chronic kidney disease (CKD) and end-stage renal disease (ESRD) programs
- Home visits for homebound and/or high risk members
- Medication reconciliation
- Social services

**Referral to care management:** To learn more about our care management program, to refer a member to the care management program, or to speak with one of our care managers, please call Monday through Friday from 8 a.m. to 5 p.m.

- For Non-SNP members: 1-866-657-5625
- For SNP members: 1-800-734-9592

For inquiries related to transplant services, you may send an email to [CPHP_HSD_Transplant_Team@humana.com](mailto:CPHP_HSD_Transplant_Team@humana.com).
SPECIAL NEEDS PLANS (SNPs)

CarePlus offers special needs plans (SNPs) for members who reside within the CarePlus service area for those individuals who are eligible for both Medicare and Medicaid. These plans offer eligible members focused benefits as well as the advantages of an interdisciplinary-care team approach to patient care. This team approach to care is dependent on the active involvement of the member’s primary care physician (PCP).

CareNeeds (HMO D-SNP) and CareNeeds PLUS (HMO D-SNP) are the SNPs for members who are eligible for Medicare and Medicaid; these benefit plans are available in every county within CarePlus’ service area.

Eligibility Requirements for Dual Eligible SNP – CareNeeds (HMO D-SNP) and CareNeeds PLUS (HMO D-SNP)

- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Reside within the CarePlus service area
- Receive some level of assistance from the state Medicaid program
  - CareNeeds PLUS (HMO D-SNP) is available to anyone receiving both Medicare and Medicaid-covered services: Qualified Medicare Beneficiary (QMB+), Specified Low-Income Medicare Beneficiary (SLMB+) and Full Benefit Dual Eligible (FBDE)
  - CareNeeds (HMO D-SNP) is available to anyone receiving both Medicare and some level of financial assistance from Medicaid: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual (QI) and Qualified Disabled Working Individual (QDWI).
- Not undergoing treatment for end-stage renal disease (ESRD) unless members of CarePlus since dialysis began

Note: All contracted providers caring for CarePlus members enrolled in a CarePlus Dual Eligible SNP (CareNeeds and CareNeeds PLUS) should be knowledgeable about the benefits covered by, including “wrap” benefits provided per CarePlus’ contract with the state of Florida.

Sample SNP Member ID Card (enlarged for better visibility)
You can easily identify SNP members by locating the plan name on the front of the CarePlus member ID card, as shown here:

Dual Eligible SNP: CareNeeds (HMO D-SNP) and CareNeeds PLUS (HMO D-SNP)
Note: If a member loses SNP eligibility and is not reinstated to the plan’s qualifying eligibility level within the six-month deeming period, he or she will be disenrolled from CarePlus.

Overview of CarePlus’ Model of Care for SNPs

CarePlus’ Model of Care (MOC) addresses preventive care as well as acute and chronic disease management across the healthcare continuum. This process is member-centric and based on an interdisciplinary care team (ICT) approach, which includes participation by members, members’ families and/or care givers, primary care physicians (PCPs), care managers, specialists, ancillary providers and/or vendors involved in the treatment of the member. CarePlus incorporates evidence-based management protocols or nationally recognized guidelines when applicable. PCPs are the clinical leaders of the ICTs. Care managers function as the member’s point of contact and are responsible for coordinating care across the continuum of need, managing the overall treatment plan and utilizing community resources, allied healthcare professionals, mental health professionals, and other providers as needed. Providers can contact CarePlus’ Care Management Team for SNP member-related issues at 1-800-734-9592, Monday through Friday from 8 a.m. to 5 p.m.

CarePlus’ MOC for dual eligible SNPs is comprised of four sections which meet the Centers for Medicare & Medicaid (CMS) standards.

MOC 1: DESCRIPTION OF SNP POPULATION (GENERAL POPULATION)

ELEMENT A: DESCRIPTION OF OVERALL SNP POPULATION

CarePlus follows all sales/marketing guidelines outlined by the Centers for Medicare & Medicaid Services to be compliant with identifying beneficiaries for the dual-eligible SNP plan. CarePlus offers SNPs for dual-eligible members, targeting categories of dual eligible beneficiaries the state of Florida deems eligible. To qualify for the D-SNP, CarePlus validates that the beneficiary is:

- Entitled to Medicare Part A and enrolled in Part B of Medicare through age or disability
- A resident within the plan’s service area
- Eligibility is based on certain levels of Medicaid eligibility based on the specific requested plan

ELEMENT B: SUBPOPULATION - MOST VULNERABLE MEMBERS

D-SNP members present as a diverse population with a small percentage bearing the most cost. CarePlus’ most vulnerable population has more urgent needs for care management services, tend to have more severe financial needs and report poorer health status. Of the four levels of stratification, the most vulnerable population is stratified with a level of severe.

Stratification is identified according to the following levels of intervention:

- Severe
- High
- Medium
- Low
Following the stratification level identified by the HRA, the care manager completes additional assessments including a stratification assessment to identify members who should be moved to the stratification of severe.

CarePlus Dual Eligible SNP Benefit Plans: CareNeeds PLUS (HMO D-SNP) enrolls dual eligible members receiving Medicaid-covered services (QMB+, SLMB+, FBDE), and CareNeeds (HMO D-SNP) enrolls dual eligible members receiving only financial assistance from Medicaid (QMB, SLMB, QDWI, QI).

MOC 2: CARE COORDINATION

ELEMENT A: SNP STAFF STRUCTURE

CarePlus has a functional structure to ensure all required services are coordinated through qualified staff with appropriate oversight. Roles include clinical and administrative functions for CarePlus and Humana.

CarePlus’ Care Management Program operates within an interdisciplinary MOC and is responsible for coordinating care in a seamless manner across the healthcare continuum using an interdisciplinary care team (ICT) approach for CarePlus members. The ICTs overall care management role includes member and caregiver evaluation, reevaluation, care planning and plan implementation, member advocacy, health support, health coaching and education, support of the member’s self-care management and ICP evaluation and modification as appropriate.

ELEMENT B: HEALTH RISK ASSESSMENT TOOL

A health-risk assessment (HRA) is required by the Centers for Medicare & Medicaid Services (CMS) for all SNP members. CarePlus utilizes the approved HRA for SNP members. The HRA produces a current health status profile and an overall risk score for each SNP member. The HRA tool scores risk across several health domains: medical, functional, cognitive, social, behavior (psychosocial and mental health), and financial risks. The HRA focuses on the acute chronic needs of the member.

ELEMENT C: INDIVIDUALIZED CARE PLAN (ICP)

All SNP members are required to have an initial HRA upon enrollment in care management and a subsequent individualized care plan (ICP). For actively managed members, all ICP information is shared, discussed, and mutually designed with the member and/or caregiver on an ongoing basis as the member works with his or her care manager.

ICPs are created, reviewed and updated at a minimum with each successful member contact. ICPs may also be updated with each transition and/or significant changes in member’s healthcare status. The care management plan includes an assessment of the member’s progress toward overcoming barriers to care and meeting treatment goals. When it has been identified that the member’s agreed-upon goals have not been met the following steps are taken:

- Barriers to achieving identified goals are defined and discussed
- Goals are modified as warranted or desired by the member and/or caregiver
- Alternative interventions are implemented to succeed in achieving the identified goals
- Changes and revisions to the ICP are documented
Care management interventions can be broadly categorized by the area of focus and services specifically tailored to the beneficiary’s needs which may include the following:

- **Medication Review:** Thorough and ongoing medication reviews, screening for member medication knowledge and adherence gaps, and offering of printed and/or verbal education on medications. Care Managers may also arrange for pharmacist review of complex medication regimens, or regimens for which numerous interactions are identified through drug interaction reviews. In addition, care managers coordinate and facilitate communication with the physician as needed, help members obtain devices that promote adherence (pill boxes, pill cutters, reminders, etc.), and refer members with financial need to pharmacy assistance programs.

- **Care Coordination:** The care manager leads the ICT and engages the support of other internal and external resources, make appropriate referrals, participate in care team conferences, and request case reviews. The care manager also facilitates communication between members and physicians and providers regarding progress toward goals i.e., the need to adjust therapy to enable a member to reach goals, and refer members to physicians and providers to evaluate condition, symptoms, medication, end of life planning, durable medical equipment needs, and home health issues or needs.

- **Care Transitions and Post-discharge Support:** Care managers work closely with the Utilization Management (UM) team to coordinate a seamless member transition between levels of care. Post discharge support needs are addressed in order to maximize member recovery and mitigate preventable readmissions.

- **Health Education:** Care managers provide members with approved educational materials related to specific health conditions and concerns. They also provide verbal coaching and written education on other general health topics common in the Medicare population, along with referrals to community-based education resources.

- **Health and Function:** Evaluation of the member’s physical and psychological health and functional status to provide education and health support, and assist the member and/or caregiver to manage their diseases as well as comorbid conditions such as COPD, CHF, depression, dementia, chronic kidney disease and end state renal disease to maintain optimal function and quality of life.

- **Interpersonal and Social Relationships:** Care managers refer members to other ICT members, providers and community resources to address issues such as social isolation and social networking, cognition and dementia, elder abuse, and caregiver strain.

- **Knowledge of When to Call the Physician:** Care managers assist members to be informed healthcare consumers and to establish a regular source of healthcare. They provide written and verbal education regarding warning signs of heart failure, diabetic complications, as well as common co-morbid complications including COPD, and depression. They also help members establish an emergency contact and action plan. Members may be supported via three way calls or warm transfers to physicians and providers for things like making an appointment or consulting with a pharmacist.

- **Preventive and Screening Services:** Care managers educate and provide reminders for obtaining health and preventions screening tests and services related to HEDIS measures, annual flu vaccine, colon and breast cancer screens, etc. They also support members in monitoring progress toward goals and self-management of their chronic health conditions.

- **Self-care Management and Personal Healthcare Preferences:** Care managers support self-care management and healthy behaviors based on the member’s stage of readiness to change. Referrals are made to providers or community-based resources for smoking cessation, alcohol or substance abuse, nutrition, physical activity and weight management.
• **Connections to Community Resources**: Evaluating needs for additional resources and support services for members, often collaborating with other staff. This multidisciplinary team locates and helps members to access services that include transportation, meal services, pharmacy assistance, and help with Medicaid applications.

• **Coordination and Access to Benefits**: Care managers evaluate member needs and support awareness of access to plan benefits and assist in coordination Medicare and Medicaid benefits.

External input is also included in an ICP when available. External input may come from:

- Primary healthcare providers/physicians
- Hospital discharge planners
- In-home nursing and social worker visits
- Behavioral healthcare providers specialist

It is imperative for providers to support the maintenance of the ICP by working collaboratively with the care manager and ensuring treatment plans, appropriate interventions and member needs are properly identified and each ICP is developed to addresses the following:

- Development of a care management plan, including prioritized goals that consider the member’s and caregiver’s goals, preferences and desired level of involvement in the care management plan
- Identification of barriers to meeting their goals or complying with the plan
- Development of a schedule for follow-up and communication
- Development and communication of their self-management plans
- A process to assess their progress against care management plans

Each ICP outlines:

- Goals and objectives as agreed upon by the member and/or caregiver
- Specific services, resources and benefits that will be accessed to meet the stated goals and objectives, as well as to fill any gaps in the member’s current level of care
- End-of-life planning for members who have not participated in this type of planning and wish to do so
- Any services or resources for which a member may qualify based on diagnoses, disability or other criteria (such as financial), are included in the ICP to ensure members are able to access all appropriate programs
- A follow-up schedule that allows both the member and his/her care manager to stay on track with meeting the stated objectives of the plan

Copies of the ICP are shared to the member when a member experiences a change in condition. Providers may also receive copies of ICPs. In addition, elements of the ICP are discussed as needed via phone with any or all members of the ICT, members and providers.

**ELEMENT D: INTERDISCIPLINARY CARE TEAM (ICT)**

The CarePlus Care Management Team delivers its services to CarePlus members within a multi-disciplinary care team model. Care management is delivered telephonically.
The ICT is member-centric and based on a collaborative approach. The ICTs overall care management role includes member and caregiver evaluation, reevaluation, care planning and plan implementation, member advocacy, health support, health coaching and education, support of the member’s self-care management and ICP evaluation and modification, as appropriate. At the center of the ICT model are the persons who serve at the core and most closely interact with one another. The care manager functions as the single point of contact for all ICT participants and is responsible for coordinating care across the continuum of need. The ICT includes at minimum, the member and/or caregiver, the member’s primary care provider and the care manager. The care manager facilitates the participation of members as part of their own ICT by directly interacting with the member, the member’s caregiver and the member’s primary care provider.

The care managers use the HRA results to develop an ICP that includes specific interventions designed to meet the member’s needs. The care manager will identify which interventions need further collaboration from ICT participants including, but not limited to, dealing with acute and chronic needs as well as health promotion and crisis intervention. The composition and structure of the ICT supporting any given member will be driven by the member’s specific set of medical, behavioral, long-term care and socio-environmental needs.

The key elements and outcomes of a person-centered ICP and ICT include:

- Forging an alliance between members and healthcare providers
- Developing the plan in partnership with the member (and family/caregiver as appropriate) and the provider/treatment team
- Ensuring the plan is individualized and based on member input regarding preferences, abilities, strengths, goals and cultural identity
- Ensuring the member understands written materials
- Immediately directing the service delivery and recovery process
- Improving person-centered and individually defined recovery goals and outcomes

While the interdisciplinary care team is a collaborative effort among the member, the care manager, the member’s primary care provider and other parties, the care manager, on behalf of the member, directs the ICT while acting as a member liaison and advocate. The model of care is physician and provider-inclusive, with PCPs driving the medical treatment plan and care managers advancing the physician’s treatment plan. Improved coordination of care among healthcare providers will be achieved by having the care manager as the designated single point of contact and facilitator of seamless transitions of care across healthcare settings, care providers, and services.

CarePlus recognizes effective and timely communication among all parties involved in the care planning and coordination processes is the key to ensure positive health outcomes and improved health status for the member. To this end, various methods are used to communicate with the beneficiary and members of the ICT.

Any number of additional support participants based on the members’ ever-changing needs may be included as members of the ICT. These ICT participants may include, but are not limited to, the medical director, the clinical pharmacist, social workers, behavioral health specialists and CarePlus utilization management nurses. The ICT collaboration can be done via face to face, written and telephonic communication.
CarePlus communicates a variety of information to practitioners, providers, delegates, and members. Examples of provider communications may include, but are not limited to:

- Letters/memos/faxes/phone calls
- Committee minutes or reports
- Provider bulletins, notices and newsletters
- Online and hard-copy reports
- Provider educational sessions
- Written instructive communications
- Quality improvement plans
- Internet/intranet (CarePlus website, email, databases)
- Provider manual for physicians, hospitals, and healthcare providers

ICT care coordination meetings may be scheduled or ad hoc, and may be telephonic, web-based, or accomplished through written communication. The occurrence and frequency of the meetings are different for each member, based on the individual level of care and healthcare needs of the member. Providers and SNP members can contact CarePlus’ Care Management Team at 1-800-734-9592.

ELEMENT E: CARE TRANSITIONS PROTOCOLS

The CarePlus Care Management Team’s objective to maintain continuity of care is to optimize a high-quality member experience during care transitions in an effort to avert complications, unnecessary hospital readmissions, and emergency room visits. CarePlus’ Care Management Team works actively to coordinate transitions, when notified, before and after admission including transitions from home to a different healthcare setting, from one healthcare setting to another, including, but not limited to, in-patient/acute facilities, skilled nursing, rehabilitation and long-term care/custodial facilities, and from a healthcare setting to home, inclusive of members receiving home healthcare. This type of support is needed to ensure continuity of care.

CarePlus recognizes that transitions of care are important events in a member’s life where the plan can coordinate care and communicate with the ICT. Various census communications are modes of communicating member information for this purpose. The plan gathers the information on the census to coordinate care when member moves from one setting to another, such as when they are admitted or discharged from a hospital or skilled nursing facility.

MOC 3: PROVIDER NETWORK

ELEMENT A: SPECIALIZED EXPERTISE

CarePlus offers SNP members a comprehensive-care-centered primary care network with medical and surgical specialists available to augment and support PCPs, as well as the needs of the targeted populations. This network includes, but is not limited to, acute care facilities, long-term care facilities, skilled nursing facilities, laboratories, radiography facilities, rehab facilities, rehabilitative specialists, mental and social health specialists, home health specialists, and end-of-life care specialists. Although CarePlus’ special needs plans offer a comprehensive network of physicians and providers, should members develop needs for services outside the current network, CarePlus may grant approval for utilization of out-of-network facilities when appropriate.
ELEMENT B: USE OF CLINICAL PRACTICE GUIDELINES (CPGs) AND CARE TRANSITION PROTOCOLS

CarePlus’ credentialing process routinely checks and ensures that potential providers have the capabilities to provide evidence-based wellness, preventive care, and continual assistance for chronic conditions before being accepted into our networks. Evidence proves that preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of emergency room visits and readmissions. Providers are encouraged to meet these baseline criteria and are routinely evaluated throughout their contract period with Humana.

Physicians and providers agree to comply with Humana’s CarePlus’ quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures, as applicable to the specific physician or provider.

CarePlus CPGs are adopted from clinically sound and reputable agencies. These guidelines are from national organizations generally accepted as experts in their fields, such as the American Diabetes Association (ADA), the American College of Cardiology (ACC), the American Heart Association (AHA), the National Heart Lung and Blood Institute (NHLBI), the American Psychiatric Association (APA), the American Academy of Child and Adolescent Psychiatry (AACAP), the National Kidney Foundation (NKF), and the Agency for Healthcare Research and Quality (AHRQ). The CPGs are available on CarePlus’ Website at https://www.careplushealthplans.com/careplus-providers.

CarePlus’ Care Management Program and care transition protocols include notifying the provider of a planned or unplanned transition. To maintain continuity of care, providers receive notification of any care transition their member experiences. The provider receives the necessary information in order to initiate coordination and contact with the member. Additionally, the CarePlus field case manager who may visit the member onsite or communicate via fax/phone with the facility is in constant contact with the CarePlus medical director regarding the member’s status, procedures and care needs.

ELEMENT C: MODEL-OF-CARE TRAINING FOR THE PROVIDER NETWORK

Written provider contracts require all employed/contracted providers to deliver services in accordance with nationally recognized clinical protocols and guidelines when available. Annual model-of-care training may be facilitated in-person by a CarePlus representative or via web based training available through CarePlus’ Health Plan Provider Webpage: (https://www.careplushealthplans.com/careplus-providers/snp).

MOC 4: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

ELEMENT A: MOC QUALITY PERFORMANCE IMPROVEMENT PLAN

CarePlus’ quality improvement program description (QIPD) contains detailed descriptions of quality improvement initiatives, which serve as a roadmap for the SNP program quality activities, including MOC performance and outcomes monitoring. Key factors in measuring quality indices are tracking measures and outcomes such as HEDIS, lab values and the practice of healthy behaviors. The QIPD is designed to detect whether the overall structure of the MOC accommodates members’ unique healthcare needs by establishing health outcomes and service goals to evaluate the effectiveness of the MOC.
CarePlus uses data collection, measurement and analysis to track issues that are relevant to the SNP population. CarePlus has developed or adopted corporate quantitative measurement activities to assess performance, and identify and prioritize areas for improvement related to medical and behavioral health issues. CarePlus identifies affected membership, selects appropriate samples, and collects valid and reliable data collected through tools. The quality improvement process activities include:

- Monitoring system-wide issues
- Identifying opportunities for improvement
- Determining the root cause
- Exploring alternatives and developing a plan of action
- Activating the plan, measuring results, evaluating effectiveness of actions, and modifying approaches as needed

In addition, CarePlus develops service goals to ensure the appropriate services are delivered to members. The developed goals include:

- Improving access and affordability of the healthcare needs for the SNP population
- Improving coordination of care and appropriate delivery of services through the direct alignment of the HRA ICP and ICT
- Enhancing care transitions across all healthcare settings and providers for SNP beneficiaries.
- Ensuring appropriate utilization of services for preventive health and chronic conditions

**ELEMENT B: MEASURABLE GOALS AND HEALTH OUTCOMES FOR THE MODEL OF CARE**

Health outcome and service goals are established to perform ongoing evaluation of the effectiveness of CarePlus D-SNP MOC. To achieve the overall goals of the program, CarePlus has established measurable goals to evaluate and measure the quality of care, outcomes, service and access for members. For each metric, goals have been established based on current experience and evidence-based medicine found by researching current literature and utilizing current NCQA standards and guidelines.

CarePlus developed measurable goals and health outcomes used to improve the healthcare needs of CarePlus D-SNP members. These goals address the D-SNP members’ needs and attempts to encourage engagement with members’ healthcare needs, educate the members on the available services and how the services can be used, and allows members to make conscious decisions about their healthcare and their benefits.

To obtain details related to the 2018 evaluation, please send an email to CPHP_HSD_Care_Management_Referrals@humana.com. In the subject line, please write “2018 MOC evaluation.”

**ELEMENT C: MEASURING EXPERIENCE OF CARE (SNP MEMBER SATISFACTION)**

Annually, an SNP-specific telephonic member satisfaction survey is conducted using internal/external resources. The survey focuses on higher acuity members because these members are touched more often by the program and are therefore best equipped to evaluate satisfaction.

**ELEMENT D: ONGOING PERFORMANCE IMPROVEMENT EVALUATION OF THE MOC**
The CarePlus SNP Quality Improvement Model of Care Evaluation (QIE), performed annually by CarePlus’ Care Management Team, is an evaluation of CarePlus’ SNP Quality Improvement Program. The annual SNP QIE also serves as a tool to summarize MOC performance, describing the SNP model of care success, barriers, and limitations encountered throughout the year, and recommendations for future initiatives and improvements. The CarePlus SNP QI program description is developed using information and insights obtained from the SNP QI Evaluation.

ELEMENT E: DISSEMINATION OF SNP MOC QUALITY PERFORMANCE

The CarePlus SNP Quality Improvement Model of Care Evaluation is presented as an executive summary to the Corporate Quality Improvement Committee. During the committee meeting a discussion occurs between key stakeholders, the committee provides recommendations and follow-up items are suggested.

Note: If you have any questions regarding CarePlus’ Model of Care for our Dual Eligible SNPs, please contact Humana Management Services for CarePlus SNPs at 1-800-734-9592. Our phone line is open Monday through Friday from 8 a.m. to 5 p.m.
Facility Responsibilities with Medicare Advantage SNPs

The following is a summary of responsibilities specific to facilities that render services to plan members enrolled in a SNP. These are intended to supplement the terms of the agreement.

- Provide or arrange for all medically necessary care and services in accordance with SNP plan benefit procedures. For those members enrolled in a Dual Eligible SNP, plan services, benefits and/or procedures must also be integrated with the agency’s Medicaid plan services. Pursuant to our contracts with CMS and the state of Florida. Refer to CarePlus’ website, https://www.careplushealthplans.com/careplus-providers/snp, for a complete listing of covered dual-eligible SNP services and a WEB link to the Agency for Health Care Administration’s Adopted Rules. Please note that the covered benefits/services listings are subject to change on an annual basis. If you do not have access to the internet, to request that a copy of the listings be mailed to you by calling the Provider Operations inquiry line at 1-866-220-5448, Monday through Friday from 8 a.m. to 5 p.m.
- Encourage members and/or caregivers to actively participate in care planning and communicate the importance of a healthy lifestyle.
- Provide education on healthcare, preventive health services and potential high risks as identified for the individual member.
- Provide pharmacotherapy consultation.
- Develop plan of care in accordance with nationally recognized clinical protocols and guidelines and applicable Plan Quality Management and Utilization Management programs.
- Ensure that members at the end-of-life understand their choices on how to receive care and are aware of their rights by providing information or assistance with things such as developing advance directives (i.e., Five Wishes®), medication management, home-based or hospice care, etc.
- Assure HIPAA compliance and accessibility of information to maintain and provide the sharing of records and reports.
- Transfer copies of medical records to other CarePlus physicians/providers upon request and at no charge to CarePlus, the member, or the requesting party, unless otherwise agreed upon.
- Assist CarePlus with early identification for transitions of care needs and ensure the member’s confidentiality is protected during the transition process.
- Be knowledgeable of Dual Eligible SNP’s covered benefits and/or services and benefits offered by the state’s Medicaid program not covered by the CarePlus’ dual-eligible SNPs to facilitate integration of benefits for the members.
- For all qualified Medicare beneficiaries (QMB/QMB+), specified low-income Medicare beneficiaries (SLMB+), and other full benefit dual eligibles (FBDE) member(s) enrolled in CarePlus’ applicable dual-eligible SNP products, providers will: (i) not file claims for Medicaid reimbursement with the Medicaid fiscal agent for any member enrolled in a SNP; (ii) not file additional claims for Medicaid deductibles, copayment, or coinsurance reimbursement with the Medicaid fiscal agent for any member enrolled in a SNP; (iii) not balance bill any SNP member for services covered under this agreement as such members are not liable for cost sharing obligations. Note: CMS’ prohibition on billing dual-eligible members applies to all Medicare Advantage providers – not only those that accept Medicaid. Furthermore, balance billing restrictions apply regardless of whether the state Medicaid agency is liable to pay the full Medicare cost-sharing amounts.
- In no event, including, but not limited to, nonpayment by the plan, insolvency of the plan, or breach of the provider agreement by either party, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any
dual-eligible SNP member or a person acting on their behalf for fees that are the responsibility of the plan or state Medicaid agency.

- For dual-eligible SNP members, a “Y” on the Cost-share protected field on the front of the member ID card will identify if a member is cost-share protected. Providers should only collect copayment, coinsurance, deductibles or other cost-share amounts from Dual Eligible SNP members if they do not have a “Y” on the Cost-shared protected field on the member ID card. For additional questions concerning cost-share protected dual eligibles, please contact the provider services queue for “Eligibility Verification” at 1-866-313-7587, Monday through Friday from 8 a.m. to 4 p.m. Eastern time.

MANDATORY – Initial and Annual Provider SNP Trainings

Federal and state regulations require that CarePlus conduct outreach and develop educational materials and/or trainings to ensure contracted providers understand the benefits available under SNPs and their critical role as healthcare providers to SNP patients. CarePlus providers are required to receive SNP training upon initial contracting and annually thereafter.

For your convenience, CarePlus has created an education-on-demand presentation that may be accessed on the CarePlus website. This presentation will help you understand the benefits offered to your CarePlus-covered SNP members and your responsibilities, as defined by CMS, in coordinating care for them.

You may access the presentation at any time by visiting the CarePlus website, https://www.careplushealthplans.com/careplus-providers/snp Under “Required Annual Training” click on “CarePlus SNP Provider Education Parts 1 and 2.” Please note that CarePlus must maintain a record of training participation for our contracted providers to substantiate its compliance with the above-mentioned regulatory requirements. Therefore, you will be asked to enter your provider information prior to viewing the presentation.

If you would prefer to receive face-to-face training, simply contact your assigned provider service executive to schedule the training.

To learn more about CarePlus SNPs or if you have any SNP-related questions, please contact your provider service executive, email CarePlus at CPHP_SNPInfo@CarePlus-HP.com or call the CarePlus Provider Operations inquiry line at 1-866-220-5448, Monday through Friday from 8 a.m. to 5 p.m.
QUALITY IMPROVEMENT PROGRAM OVERVIEW

Scope and Purpose
The purpose of CarePlus’ Quality Improvement (QI) Program is to monitor, evaluate and facilitate improvement in the quality of healthcare services provided to CarePlus members and to fulfill regulatory and statutory requirements and standards of accrediting bodies, such as the Accreditation Association for Ambulatory Health Care (AAAHC). Our QI program is aligned with The National Quality Strategy (NQS) which is led by the Agency for Healthcare Research and Quality (AHRQ) on behalf of the U.S. Department of Health and Human Services (HHS). The NQS serves as a catalyst and compass for a nationwide focus on quality improvement efforts. The NQS is guided by three aims: better care, healthy people/healthy communities, and affordable care.

The Centers for Medicare & Medicaid Services (CMS) Quality Strategy was built on the foundation of the HHS/NQS to optimize health outcomes by leading clinical quality improvement and health system transformation. By incorporating the CMS and HHS/NQS into our QI Program, CarePlus is supporting the delivery of consistent high-quality care, promoting efficient outcomes in the healthcare system and ensuring that healthcare remains affordable for all our members.

Data Collection/Monitoring
As part of the company-wide quality improvement program, the CarePlus QI and Accreditation department systematically monitors and collects data to be used for evaluation of care and services.

Data collection may include, but not be limited to, the following:

- Retrospective clinical quality of care investigations/record reviews
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS)
- Medicare quality improvements/chronic care improvement projects
- Clinical practice guidelines adherence reviews
- Medical record documentation reviews

Data is derived from multiple sources, including medical records, claims and encounter data, member and provider surveys, complaint/grievance reports, healthcare services staff, peer review and provider site visits.

Data from outside surveys, including the Health Outcomes Survey and the Consumer Assessment of Healthcare Providers and Systems performed for Medicare members by CMS, are reviewed for improvement opportunities.

Monitoring activities are designed for a broad range of healthcare issues with a focus on identifying areas of vulnerability, and the tracking and trending related data. Ongoing monitoring activities include review for compliance with medical record documentation standards, HEDIS measures, and other regulatory and accrediting agency requirements.

This is performed through, but not limited to:

- Provider site visits
- Review of the provider practice patterns
- Medical record documentation reviews
- Review of member outcomes
- Evaluation of clinical and service areas of concern
- Evaluation and trending of member and provider complaints, grievances and appeals
- Evaluation of Healthcare Effectiveness Data and Information Set data

Quality-of-care Issues

CarePlus associates, including the QI and Accreditation department, quality operations compliance and accreditation (QOCA), risk management, health services, member services, regulatory compliance, and outside entities, Florida’s Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and CMS communicate potential quality of care issues, which are investigated through the QOCA QI and Accreditation department. QOCA QI and Accreditation associates identify, investigate, analyze, monitor, and evaluate individual issues or trends for specific providers. Referrals are generated by medical record audits, care management, authorizations, member service calls from members, grievances, provider calls, analysis of data, and delegated networks, as well as other sources. Referrals may include quality issues, and access/availability concerns. Issues with implications for risk management are referred to the risk manager. Resolution may include notification of the provider, corrective action plans, referral to the chief medical officer, or referral to the peer review committee, as appropriate.

Beneficiary Complaints

As required by the Medicare statute and regulations, CarePlus participates with the Florida BFCC-QIO, KEPRO (formerly FMQAI, Florida Medical Quality Assurance Inc.). CarePlus collaborates with the BFCC-QIO in the following broad activities:

- Mandatory case review activities – medical record reviews, which determine whether the medical services provided to the Medicare beneficiaries are medically necessary, furnished at the appropriate level of care and of a quality that meets professionally recognized standards of care
- Beneficiary complaints – medical record reviews which determine quality of care provided to beneficiaries
- Cooperative project activities – collaborative efforts with healthcare providers and other groups, which result in measurable improvement of processes and outcomes, related to healthcare

Clinical Practice Guidelines

CarePlus clinical practice guidelines are adopted from clinically sound and reputable agencies. These guidelines are taken from national organizations generally accepted in their fields as experts to include, but not limited to: the American Diabetes Association (ADA), the American College of Cardiology, the American Heart Association (AHA), the National Heart, Lung, and Blood Institute, the National Kidney Foundation, and the Agency for Healthcare Research and Quality (AHRQ).

CarePlus publishes medical guidelines from a number of well-respected national sources. These guidelines may have some differences in recommendations. Information contained in the guidelines is not a substitute for a healthcare professional's clinical judgment and is not always applicable to an individual. Therefore, the healthcare professional and patient should work in partnership in the decision-making process regarding the patient's treatment. Furthermore, using this information will not guarantee a specific outcome for each patient. None of the information in the guidelines is intended to interfere with
or prohibit clinical decisions made by a treating healthcare professional regarding medically available treatment options for patients. Since publication of these guidelines is not a promise of coverage, individuals should review their coverage to determine benefits.

Links to other websites are provided for your convenience only and do not constitute or imply endorsement by CarePlus of these sites, products or services described on these sites, or of any other material contained therein. CarePlus disclaims responsibility for their content and accuracy.

A copy of CarePlus’ Clinical Practice Guidelines is also available online at https://www.careplushealthplans.com/careplus-providers/updates.

Clinical practice guidelines are resources for CarePlus-contracted physicians and other CarePlus-contracted healthcare professionals. CarePlus has adopted the following guidelines:

**Adult immunizations**
Centers for Disease Control and Prevention
Recommend [immunization schedule for adults aged 19 years or older, United States 2018](https://www.cdc.gov/vaccines/schedules/hcp/adult.html).

**Asthma care**
Guidelines for the diagnosis and management of asthma (EPR-3)

**Atherosclerotic cardiovascular disease**
AHA (American Heart Association)/ACCF (American College of Cardiology Foundation)
Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2011 Update

**Breast cancer screening**
Breast cancer: Screening

**Cholesterol treatment**
Guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults

**Chronic obstructive pulmonary disease (COPD)**
Global Initiative for Chronic Obstructive Lung Disease (GOLD) – Global Strategy for The Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease (COPD), 2019 Report
Guidelines on diagnosis and treatment of stable COPD

**Depression**
Institute for Clinical Systems Improvement (ICSI): Depression, Adult in Primary Care (March 2016)
**Depression, Adult in Primary Care**

**Diabetes**
American Diabetes Association, Executive Summary: Standards of Medical Care in Diabetes – 2014
*Executive Summary: Standards of medical care in diabetes – 2014*

**Heart failure**
2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure; A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America; Clyde W. Yancy, Mariell Jessup, Biykem Bozkurt, Javed Butler, Donald E. Casey Jr., Monica M. Colvin, Mark H. Drazner, Gerasimos S. Filippatos, Gregg C. Fonarow, Michael M. Givertz, Steven M. Hollenberg, JoAnn Lindenfeld, Frederick A. Masoudi, Patrick E. McBride, Pamela N. Peterson, Lynne Warner Stevenson and Cheryl Westlake
*2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure*

**Heart Risk Calculator**
*Heart risk calculator*

**Hypertension**
*Guideline for Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults*

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**Kidney disease**
National Kidney Foundation Guidelines and Commentaries – Evidence-based clinical practice guidelines for all stages of chronic kidney disease
*Guidelines and commentaries*

**Medical records documentation guidelines**
CarePlus has adopted guidelines based on federal and state medical record documentation requirements. Refer to the CarePlus provider manual at
[https://www.careplushealthplans.com/careplus-providers/forms.](https://www.careplushealthplans.com/careplus-providers/forms)

**Obesity screening in adults**
Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions, September 2018
*Behavioral interventions*
Preventive care
Guide to Clinical Preventive Services, 2014

Recommendations of the U.S. Preventive Services Task Force

Valvular heart disease

AHA/ACC Guideline

Well-woman routine care
ACOG (The American College of Obstetricians and Gynecologists)

Well-woman recommendations

Additional preventive care guidelines from specialty organizations:

Atrial fibrillation guidelines
2014 AHA /ACC/HRS (American Heart Association/American College of Cardiology/Heart Rhythm Society) Guideline for the Management of Patients with Atrial Fibrillation

http://www.onlinejacc.org/content/64/21/2246

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Clinical toolkit, atrial fibrillation
The Cardiosource® site produced by the American College of Cardiology Foundation


Colorectal cancer screening guidelines
American Cancer Society guidelines for colorectal cancer early detection Updated 2018


Primary prevention of cardiovascular disease and stroke
Primary prevention of cardiovascular disease and stroke
ACC (American College of Cardiology)/AHA (American Heart Association) Prevention Guideline: 2013


https://www.ahajournals.org/doi/full/10.1161/01.cir.0000437741.48606.98

Smoking cessation
Treating Tobacco Use and Dependence: 2008 Update – Clinical Practice Guideline

https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html

CarePlus periodically monitors compliance with nationally recognized clinical practice guidelines.
Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a set of performance measures established by the National Committee for Quality Assurance (NCQA) for the managed care industry. Each year, CarePlus collects data from a randomly selected sample of members for HEDIS® reporting purposes. Medicare Advantage plans are required to report their results annually to the Center for Medicare and Medicaid (CMS), NCQA and the Agency for Health Care Administration (AHCA) use this information to monitor the performance of health plans.

Altogether, HEDIS published across a number of volumes and includes 96 measures across 6 domains:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures collected using electronic clinical data systems

As a primary care physician, certain measures are indicative of your practice for preventive care and chronic condition management. Below are the Effectiveness of Care HEDIS measures applicable to the Medicare line of business. CarePlus is required to report the measures to governing partners.

Prevention Screening Measures

- **Adult BMI Assessment** – Percentage of members 18-74 years old who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year
- **Breast Cancer Screening** – Percentage of female members 50-74 years old who had a mammogram any time on or between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year.
- **Colorectal Cancer Screening** – Percentage of members 50-75 years old who had an appropriate screening for colorectal cancer. Documentation must include one of the following:
  - Fecal occult blood testing (either guaiac or immunochemical) testing during measurement year
  - FIT-DNA test during the measurement year or the two years prior to the measurement year
  - CT colonography during the measurement year or the four years prior to the measurement year
  - Flexible sigmoidoscopy during the measurement year or four years prior to the measurement year
  - Colonoscopy during the measurement year or nine years prior to the measurement year
- **Influenza Vaccination** – Percentage of members who reported having received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS survey was completed.
Respiratory Condition Measures

- **Appropriate Testing for Pharyngitis** - The percentage of episodes for members 3 and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
- **Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)** – The percentage of members 40 and older with a new diagnosis or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
- **Pharmacotherapy Management of COPD Exacerbation** – The percentage of COPD exacerbations for members 40 and older who had an acute inpatient discharge or ED encounter on or between Jan. 1 – Nov. 30 of the measurement year and were dispensed appropriate medications (systemic corticosteroid within 14 days of event and bronchodilator within 30 days of event). Two rates are reported:
  1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event
  2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event

Cardiovascular Measures

- **Controlling High Blood Pressure** – The percentage of members 18-85 who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
  **Note:** The representative BP is most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”
- **Persistence of Beta-blocker Treatment After a Heart Attack** – The percentage of members 18 and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.
- **Statin Therapy for Patients with Cardiovascular Disease** – The percentage of males 21-75 and females 40-75 years old during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:
  - Received statin therapy. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.
  - Statin adherence 80 percent. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period.

Diabetes Measures

- **Comprehensive Diabetes Care** – Percentage of members 18-75 years old, with a diagnosis of diabetes (Type 1 or Type 2) who had each of the following:
Musculoskeletal Measures

- **Disease Modifying Antirheumatic Drug Therapy for Rheumatoid Arthritis** – Percentage of members 18 and older who were diagnosed with rheumatoid arthritis who have had at least one ambulatory prescription dispensed for a disease modifying antirheumatic drug (DMARD).

- **Osteoporosis Management in Women Who Had a Fracture** – Percentage of female members 67-85 who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the six months after the fracture.

Behavioral Health Measures

- **Follow-up After Hospitalization for Mental Illness** – The percentage of discharges for members 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:
  - The percentage of discharges for which the member received follow-up within 30 days after discharge.
  - The percentage of discharges for which the member received follow-up within seven days after discharge.

- **Follow-up After Emergency Department Visit for Mental Illness** – The percentage of emergency department (ED) visits for members 6 and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:
  - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).

- **Follow-up After High-intensity Care for Substance Use Disorder** - The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:
  - The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
  - The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

- **Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence** – The percentage of emergency department (ED) visits for members 13 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:
  - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
  - The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).

- **Antidepressant Medication Management** – The percentage of members 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.
  - Effective acute-phase treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
  - Effective Continuation phase treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (six months).

- **Pharmacotherapy for Opioid Use Disorder** - The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.

- **Adherence to Antipsychotic Medications for Individuals With Schizophrenia** - The percentage of members 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

**Medication Management and Care Coordination**

- **Medication Reconciliation Post-discharge (MRP)** – The percentage of discharges from Jan. 1-Dec. 1 of the measurement year for members 18 and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

- **Transitions of Care (TRC)** – The percentage of discharges for members 18 and older who had each of the following. Four rates are reported:
- Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission or the following day.
- Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge or the following day.
- Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

- **Follow-up After Emergency Department Visit for People With Multiple High-risk Chronic Conditions (FMC)** – The percentage of emergency department (ED) visits for members 18 and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit.

**Overuse/Appropriateness**

- **Non-recommended PSA-based Screening in Older Men (PSA)** – The percentage of men 70 and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening. **Note:** A lower rate indicates better performance.
- **Appropriate Treatment for Upper Respiratory Infection (URI)** - The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.
- **Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)** - The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.
- **Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)** – The percentage of Medicare members 65 and older who have evidence of an underlying disease, condition, or health concern, and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Report each of the three rates separately and as a total rate.
  - A history of falls and a prescription for anticonvulsants, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or antidepressants (SSRIs, tricyclic antidepressants and SNRIs).
  - Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, or anticholinergic agents.
  - Chronic kidney disease and prescription for Cox-2 selective NSAIDs or nonaspirin NSAIDs.

  Total rate (the sum of the three numerators divided by the sum of the three denominators). Members with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify).

- **Use of High-Risk Medications in Older Adults (DAE)** – The percentage of Medicare members 66 years of age and older who had at least two dispensing events for the same high-risk medication.
• **Use of Opioids at High Dosage** – The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

• **Use of Opioids From Multiple Providers** – The proportion of members 18 and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. Three rates are reported:
  - Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
  - Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
  - Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

• **Risk of Continued Opioid Use** – The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:
  - The percentage of members whose new episode of opioid use lasts at least 15 days in a 30-day period.
  - The percentage of members whose new episode of opioid use lasts at least 31 days in a 62-day period.
  **Note:** A lower rate indicates better performance

**Access/Availability of Care Measures**

• **Adults’ Access to Preventive/Ambulatory Health Services** – The percentage of members 20 years and older who had ambulatory or preventive care visit during the measurement year.

• **Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment** – The percentage of members with a new episode of alcohol or other drug dependence (AOD) who received the following:
  - Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
  - Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.

**Risk-Adjusted Utilization**

• **Plan All-cause Readmission** – For members 18 and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

• **Hospitalization Following Discharge From a Skilled Nursing Facility** – For members 18 years of age and older, the percentage of skilled nursing facility discharges to the community
that were followed by an unplanned acute hospitalization for any diagnosis within 30 and 60 days.

- **Acute Hospital Utilization** – For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year reported by Surgery, Medicine and Total.

- **Emergency Department Utilization** – For members 18 and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.

- **Hospitalization for Potentially Preventable Complications (HPC)** – For members 67 and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions. Ambulatory care sensitive condition. An acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions included in this measure are:

  - Chronic ACSC:
    - Diabetes short-term complications
    - Diabetes long-term complications
    - Uncontrolled diabetes
    - Lower-extremity amputation among patients with diabetes
    - COPD
    - Asthma
    - Hypertension
    - Heart failure
  - Acute ACSC:
    - Bacterial pneumonia
    - Urinary tract infection
    - Cellulitis
    - Pressure ulcer

**Special Needs Plans (SNP) Measures**

CMS also collects audited data from all SNPs that have 30 or more members enrolled. CMS/NCQA are monitoring and evaluating at the individual SNP benefit package level.

The following is a list of HEDIS measures selected for SNP benefit packages:

- Adult BMI Assessment (ABA)
- Breast Cancer Screening (BCS)
- Care for Older Adults (COA)
- Appropriate Testing for Pharyngitis Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy of COPD Exacerbation (PCE)
- Controlling High Blood Pressure (CBP)
- Persistence of Beta Blocker Treatment After a Heart Attack (PBH)
- Statin Therapy for Patients With Cardiovascular Disease (SPC)
- Comprehensive Diabetes Care (CDC)
- Statin Therapy for Patients With Diabetes (SPD)
- Statin Therapy for Patients with Diabetes (SPD)
- Disease-Modifying Antirheumatic Drug Therapy for Rheumatoid Arthritis (ART)
• Antidepressant Medication Management (AMM)
• Follow-up After Hospitalization for Mental Illness (FUH)
• Follow-up After Emergency Department Visit for Mental Illness (FUM)
• Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
• Pharmacotherapy for Opioid Use Disorder (POD)
• Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
• Use of Opioids at High Dosage (UOD)
• Use of Opioids From Multiple Providers (UOP)
• Risk of Continued Opioid Use (COU)
• Appropriate Treatment for Upper Respiratory Infection (URI)
• Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
• BCR Board Certification

SNP-only measures

• Care for Older Adults – The percentage of members 66 and older who had each of the following:
  - Advance care planning
  - Medication review
  - Functional status assessment
  - Pain assessment

Ways healthcare providers can support HEDIS initiatives, based on NCQA guidelines:

• Submit appropriately coded claims/encounters data for each service rendered in a timely manner
• Submit encounters electronically and work reject reports completely
• Provide lab data as requested
• Keep accurate, legible and complete medical records for their patients
• Help ensure HEDIS-related preventive screenings, tests and vaccines are performed timely
• Allow access to or provide records as requested (online capability)

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Overview
NCQA and the Centers for Medicare & Medicaid Services (CMS) require health plans to conduct a member satisfaction survey, called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). A random sample of health plan members is selected from eligible Medicare Advantage (MA) contracts to participate in the CAHPS program each year. Results are produced annually and compared with national benchmarks. The surveys are administered in early spring by mail, with telephonic follow-up for nonresponders; results are available later in the year.

CAHPS is a member survey that gauges satisfaction with services provided by the health plan and member perception of provider accessibility, the patient-physician relationship and healthcare provider communication. The survey has approximately 68 questions; results are reported in composites and
overall ratings. Below are the CAHPS categories applicable to providers and facilities along with and along with respective sample questions applied towards the Star Ratings.

**Getting Needed Care:**
- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last six months, how often was it easy to get the care, tests or treatment you needed?

**Getting Appointments and Care Quickly:**
- In the last six months, when you needed care right away, how often did you get care as soon as you needed?
- In the last six months, how often did you get an appointment for a check-up or routine care as soon as you needed?

**Care Coordination:**
- In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor’s office follow up to give you those results?
- In the last six months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last six months, did you get the help you needed from your personal doctor’s office to manage your care among these different providers and services?
- In the last six months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

**Overall Rating of Healthcare Quality:**
- Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last six months?

**Medicare-Specific and HEDIS Measures: Influenza Vaccination:**
- Have you had a flu shot since July 1, 2018?

**Medicare Specific and HEDIS Measures: Pneumonia Shot:**
- Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person’s lifetime and is different from the flu shot. It is also called the pneumococcal vaccine.

**4. Health Outcome Survey (HOS)**

The Health Outcomes Survey (HOS) is a Centers for Medicare & Medicaid Services (CMS) survey that gathers meaningful health status data from people with Medicare. Like the CMS Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS), HOS is part of an integrated system for use in quality improvement activities and to establish accountability in managed care. All managed care plans with Medicare Advantage (MA) contracts, including CarePlus, must participate.
A random sample of Medicare beneficiaries receives a baseline survey in the spring. Two years later, the same respondents are surveyed for follow-up measurement. Survey completion is voluntary. The difference in the scores for the two-year period shows if a member’s physical and mental health status is categorized as better than, the same as or worse than expected. Member responses are shared with CarePlus for use in quality improvement initiatives.

HOS may be of interest to physicians as they could receive questions about the survey from their Medicare patients. Survey questions pertain to patient-physician relationships and help identify areas for improving member health outcomes. Five HOS measures (two functional health measures and three HEDIS Effectiveness of Care measures) are included in the annual Medicare Part C Star Ratings:

Functional Health (Outcome) measures
- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health

HEDIS Effectiveness of Care measures
- Monitoring Physical Activity
- Improving Bladder Control
- Reducing the Risk of Falling

Who conducts the survey?
A CMS-approved Medicare survey vendor conducts the survey.

For more information about the CMS Star Ratings, HEDIS®, CAHPS and HOS, please email CarePlus’ Star maximization department at CPHP.STARSDEPT@careplus-hp.com

Health Insurance Portability and Accountability Act (HIPAA)

Per the U.S. Department of Labor, HIPAA was initially passed in 1996 to “improve portability and continuity of health insurance coverage.” As a result, there are more consumer protections regarding options for coverage (http://aspe.hhs.gov/admnsimp/pl104191.htm). Later “rules,” or provisions, were passed in 2001 and 2003 to protect privacy, confidentiality and security of individually identifiable health information. This includes the establishment of security standards for electronic protected health information.

Facilities and CarePlus are required to have sufficient safeguards regarding this type of information, including who may access it, how much of it may be accessed by any individual, and how it is retained and transmitted.

http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html
http://www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html

We anticipate that you may have questions about whether the HIPAA Privacy Rule permits you to disclose your patients’ (our members) medical information to us for these activities without written authorization from your patients.

Section 164.506(c)(4) of the HIPAA Privacy Rule explicitly permits you to make this type of disclosure to CarePlus without a written authorization. Additionally, the Office of Civil Rights (the federal agency tasked with enforcing the privacy rule) has also made this point clear. It wrote in its Dec. 3, 2002,
Guidance on the Privacy Rule that: “A covered entity may disclose protected health information to another covered entity for certain healthcare operation activities of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the information and the protected health information pertains to the relationship, and the disclosure is for a quality-related healthcare operations activity.”

As the privacy rule and the Office of Civil Rights have made clear, you do not need a written authorization from your patients, who are or have been members of CarePlus, to disclose their medical information to us for HEDIS and other quality improvement, accreditation or regulatory activities.
MEDICAL RECORD DOCUMENTATION STANDARDS

CarePlus conducts annual review of medical records for a sample of providers providing primary care services to CarePlus members using a standardized medical record review tool. This record review is part of the annual compliance guidelines stipulated by AAAHC, state regulatory agencies and CMS.

Medical record elements for review include compliance with the following:

**Working diagnosis/clinical impression**
The diagnosis is appropriate for the findings in the current history and physical examination.

**Medication profile is maintained**
The record reflects a current review and update at each visit of all individual patient medications, including over-the-counter products and dietary supplements when information is available to provider.

**Plan of care documented**
Treatment, diagnostic and therapeutic procedures are consistent with clinical impression or working diagnosis.

**Follow-up of acute or chronic problems**
The record documents appropriate and timely consultation and follow-up of referrals, tests and findings.

**Member identification on each page**
The record includes appropriate patient identifiers including, at a minimum, name, identification number (if appropriate), date of birth, gender and responsible party (if applicable).

**Record is legible**
Clinical record entries are legible and easily accessible within the record by the organization’s personnel.

**Record is organized**
Content and format of the record are uniform and consistent with the organization’s clinical records policies.

**Health history documented**
Reports, histories and physicals, progress notes and other patient information (such as laboratory reports, X-ray readings, operative reports and consultations) were reviewed and incorporated into the record in a timely manner.

**Previous records**
For records with multiple visits/admissions or complex and lengthy records, diagnostic summaries are used in accordance with organization policies and procedures. If applicable, records of patients treated elsewhere or transferred to another healthcare provider are present.

**Allergies/untoward drug reactions**
Presence or absence of allergies and untoward reactions to drugs or materials are recorded in a prominent and consistent location, verified at each patient encounter and updated when new allergies or sensitivities are identified.

**Entries dated**
All entries must be dated (and include department, if departmentalized).
Chief/subjective complaint recorded
Chief complaint or purpose of visit as told by the member, or family member, must be recorded.

Clinical/objective findings
Clinical findings, to include the physical findings related to the subjective complaint, should be recorded.

Diagnosis/objective findings
Diagnosis or clinical impressions must be in the record.

Consults/lab/diagnostic reports
Documentation is present of consultations, lab, X-ray, imaging or other studies ordered. Results should be filed in the medical record and initialed by the primary care physician, thereby signifying review. Abnormal X-ray, lab and imaging study results should have an explicit notation in the medical record regarding follow-up plans and notification to patient of all results (positive and negative).

Member education/participation
Disposition, recommendations and instructions given to the patient should be clearly documented within the record.

Entries authenticated
Authentication and verification of contents by healthcare professionals should be present.

Follow-up of missed and canceled appointments
Documentation regarding missed and canceled appointments should be recorded in the record.

Entries signed
Signature of physician or other author of the clinical record entry is recorded in the record.

Communication of abnormal labs/diagnostic findings
Significant patient advice given by telephone, online or after hours is entered in the clinical record and appropriately signed or initialed.

Clinical research
Any notation in the clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research-related care.

Advance directives
If applicable, the record reflects discussions with the patient concerning the necessity, appropriateness and risks of proposed care, surgery or procedure, as well as discussions of treatment alternatives and advance directives. If response is yes to an advance directive, a copy of the directive must be included in the medical record.

For any comments or questions you might have regarding CarePlus’ QI Program, you may call 305-626-5195.
CULTURAL GAPS IN CARE

A report by the Institute of Medicine, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” released on March 20, 2002 (for URL, see below: Resources for Continuing Medical Education), found racial and ethnic differences in the quality of care delivered across a wide range of settings and disease conditions, even when controlling for socioeconomic factors such as income and insurance coverage. Annual National Healthcare Disparities reports from the Agency for Healthcare Research and Quality (AHRQ) have confirmed that these gaps persist in the American healthcare system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult when doctors and patients come from different cultures. Language barriers, cultural norms, beliefs and attitudes that determine health-care-seeking behaviors can contribute to miscommunication. By becoming more aware of their patients’ cultural needs and by improving communication with their growing numbers of diverse patients, doctors can address racial and ethnic gaps in healthcare.

CarePlus offers a number of initiatives intended to deliver healthcare services to all members regardless of race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or socioeconomic status. Some of these initiatives include member services representatives who are fluent in English and Spanish, translation services provided by a CarePlus-certified vendor, a Spanish-language website and education of CarePlus associates in cultural competency. While making strides in addressing diversity and disparities in healthcare, CarePlus continues to work to improve its current processes.

Resources for Continuing Medical Education
Another CarePlus initiative offers healthcare providers resources and materials, including the following tools, to improve awareness of gaps in care and to promote culturally competent care.

Web-based module for continuing education credit

Learn more about the cultures you serve
- Culture, Language and Health Literacy, a website run by the Health Resources and Services Administration of the U.S. Department of Health & Human Services, https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy

Toolkits for clear health communication and language services
- Ask Me 3, a quick and effective tool for raising awareness about health literacy and improving communication between doctors and patients, from the Partnership for Clear Health Communication, http://www.ihs.gov/healthcommunications/documents/AskMe_8-pg_NatAmer.pdf
- The Guide to Providing Effective Communication and Language Assistance Services, a document from the Office of Minority Health that can help physicians better serve patients with limited English proficiency, hclsig.thinkculturalhealth.hhs.gov/
Frameworks and guidelines for culturally appropriate care

- **National Standards for Culturally and Linguistically Appropriate Services in Health Care**, a report published by the U.S. Department of Health & Human Services, [https://www.thinkculturalhealth.hhs.gov/clas](https://www.thinkculturalhealth.hhs.gov/clas)
- **One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations**, a guide from the Joint Commission, [http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf](http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf)

Additional sources that address healthcare disparities

MEMBER GRIEVANCE & APPEALS

CarePlus is mandated to meet CMS requirements for processing member grievance and appeals. This information is provided to you so that you may assist CarePlus members with this process, should they request your assistance. CarePlus has a designated department and representatives who handle all member grievances and appeals.

GRIEVANCE PROCESS

A grievance is an expression of dissatisfaction with any aspect of the operations activities or behavior of CarePlus or its providers in the provision of health care items, services, or prescription drugs regardless of whether any remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

A grievance may be filed by a member or his or her authorized representative, either orally or in writing to CarePlus.

- The Grievance or Appeal Form is available for download from our website at https://www.careplushealthplans.com/members/. The member/authorized representative may also contact our Member Services department (1-800-794-5907) to request a Grievance or Appeal Form. The written grievance request may be submitted to the Grievance and Appeals Department at the following address or fax number:

  CAREPLUS HEALTH PLANS INC.
  Attention: Grievance & Appeals Department
  11430 NW 20th St., Suite 300
  Miami, FL 33172
  Fax: 1 (800) 956-4288

- If the “Grievance or Appeal Form” is not utilized, the member/authorized representative has the right to submit his/her own written request to CarePlus. At minimum, the following information must be provided:

  o (a) Member’s name, address, phone number and identification number
  o (b) Details about the issue
  o (c) Any previous contact with us (CarePlus)
  o (d) Date of service/occurrence
  o (e) Provider name (if applicable)
  o (f) Description of relief sought
  o (g) Member’s signature or that of the authorized representative
  o (h) Date grievance was signed

- Otherwise, the member/authorized representative can call CarePlus’ Member Services at 1-800-794-5907; TTY: 711 and have (a-h listed above) ready for the Member Services representative. From Oct. 1- March 31, we are open from 8 a.m. to 8 p.m. seven days a week. From April 1 to Sept. 30, we are open Monday through Friday, 8 a.m. to 8 p.m.
CarePlus reviews a grievance and notifies the member and/or the authorized representative of its resolution as expeditiously as the member’s health requires, but no later than 30 calendar days from the date the grievance is received for standard grievances or 24 hours for expedited grievance requests.

- The time frame for a standard grievance may be extended if either the member or member’s authorized representative requests an extension, or if CarePlus justifies the necessity for additional information and documents that the extension is in the best interest of the member.

A quality-of-care grievance may be filed through CarePlus’ grievance process (listed above) and/or a Quality Improvement Organization (QIO). A QIO will determine whether the quality of services (including both inpatient and outpatient services) provided by CarePlus meets the professionally recognized standards of healthcare, including whether appropriate healthcare services have been provided in appropriate settings. QIO submissions must be sent to KEPRO, Florida’s Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO) at:

KEPRO
Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Toll-free phone: 1-888 317-0751;
Local phone: 1-813-280-8256
TTY: 1-855-843-4776
Fax: 1-833-868-4058

Representatives filing on behalf a member

- A representative is an individual appointed by a member, or authorized under state or other applicable law, to act on behalf of a member involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member in filing a grievance, or in dealing with any of the levels of the appeals process.
- A member may appoint any individual (such as a relative, friend, advocate, attorney or physician) to act as his or her representative. However, if a member wishes to appoint a representative to act on his or her behalf, the member must submit a written representative statement to CarePlus. The Appointment of Representative Form is preferred but a member may submit an equivalent written notice to make the appointment. A notice is equivalent if it:
  - Includes the name, address, and telephone number of the member
  - Includes the member’s Medicare Beneficiary Identifier (MBI) or CarePlus member number
  - Includes the name, address, and telephone number of the individual being appointed
  - Includes the appointed representative’s professional status or relationship to the party
  - Includes a written explanation of the purpose and scope of the representation
  - Contains a statement that the member is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative
  - Is signed and dated by the member making the appointment
  - Is signed and dated by the individual being appointed as representative, and is accompanied by a statement that the individual accepts the appointment
• Unless revoked, the representation is valid for one year from the date the appointment is signed by both the member and the representative.

Note: A provider or physician may **not** charge a member for representation in filing a grievance, organization/coverage determination or appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes.
An appeal includes any of the procedures that deal with the review of adverse initial determinations made by CarePlus on healthcare services/prescription drug benefits a member believes he or she is entitled to receive, including delay in providing (when a delay would adversely affect the health of the member), arranging for, or approving the healthcare services/drug coverage or any amounts the member must pay for a service or drug.

**Appeal levels**

There are five levels of Medicare appeals:

- Reconsideration [Part B & C]/Redetermination [Part D]
- Hearing by an administrative law judge/attorney adjudicator (ALJ) if the amount in controversy is met
- Medicare Appeals Council (Council)
- Judicial review if the amount in controversy is met

**Medical care**: includes medical items and services (Part C) as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. Please refer to the timeframes listed below to see how Part B prescription drugs are different from the timeframes for Part C medical items and services.

A **reconsideration** is an appeal to CarePlus about a Part C medical care coverage decision. This is the member’s first step in the appeals process after an adverse organization determination. Care Plus or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

A **redetermination** is an appeal to CarePlus about a Part D drug coverage decision. This is the member’s first step in the appeals process, which involves CarePlus re-evaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

**Requesting a standard reconsideration/redetermination**

- A member, member’s representative, or treating physician (subject to the notice requirements listed below) may request a standard reconsideration/redetermination by filing a written request with CarePlus to the mailing address or fax referenced in the grievance section.
  - Completion of the Grievance or Appeal Form is preferred but the requestor may submit their own form as long as it contains the following information:
    - (a) Member’s name, address, telephone number, member number
    - (b) Reasons for the appeal, including identifying which denial is being appealed;
    - (c) Provider name and contact information
    - (d) Requestor’s name and signature (optional) unless proof of authorized status is necessary;
    - (e) Date the appeal was signed
(f) Submission of any supporting evidence

(g) For prescription drug requests:
- Prescription drug being requested
- If the appeal relates to a decision by CarePlus to deny a drug that is not on CarePlus’ formulary the physician/prescriber must indicate that all the drugs on any tier of CarePlus’ formulary would not be as effective to treat the member’s condition as the requested off-formulary drug or would harm the member’s health.

The Grievance or Appeal Form is available for download from our website at https://www.careplushealthplans.com/members/. You may also contact our Member Services department to request a Grievance or Appeal Form.

For Part D appeals, the Medicare Part D Redetermination Request Form is available for download on our website at https://www.careplushealthplans.com/members/drug-coverage-determination. You also may contact our Member Services department to request a redetermination request form.

**Standard reconsideration/redeterminations requests from physicians**

- A physician who is providing treatment to a member may, upon providing notice to the member, request a standard reconsideration on the member’s behalf without submitting a representative form:
  - If the reconsideration/redetermination comes from the member’s primary care physician within CarePlus’ network, no member notification is required.
  - If the reconsideration/redetermination comes from either a physician within CarePlus’ network, or a non-contracted physician, and the member’s records indicate he or she visited the physician at least once before, CarePlus can assume the physician has informed the member about the request and no further verification is needed.
  - If it appears to be the first contact between the physician requesting the reconsideration/redetermination and the member, CarePlus will need to confirm that the physician notified the member about his/her reconsideration/redetermination request.

**Requesting expedited reconsiderations/redeterminations**

- A member, member’s representative or any physician/prescriber, regardless of whether they are affiliated with CarePlus, may request that CarePlus expedite a reconsideration/redetermination in situations where applying the standard procedure could seriously jeopardize the member’s life, health or ability to regain maximum function.
- A physician/prescriber does not need to be an authorized representative to request an expedited appeal on behalf of the member.
  
  **Note:** a request for payment of a service already provided to the member is not eligible to be reviewed as an expedited appeal.
- To request an expedited appeal, the member, member’s representative or physician/prescriber must submit an oral or written request (see Requesting a Standard Reconsideration/Redetermination section above for written requests) directly to CarePlus by either calling CarePlus’ Member Services Department or mailing/faxing the request at the contact information noted above (under CarePlus Health Plans).
Note: While exact words are not required, the physician/prescriber must indicate that applying the standard timeframe could seriously jeopardize the life or health of the member, or the member’s ability to regain maximum function. If CarePlus receives this expedited request from a physician/prescriber then we will process the appeal under expedited timeframes.

Time frames

- A reconsideration/redetermination request must be filed within 60 calendar days from the date of the notice of the organization/coverage determination (initial denial).
  - CarePlus will only extend a timeframe for filing a reconsideration/redetermination if good cause is shown. A request to file after the timeframe must be in writing and stay why the request was not filed on time. Good cause will be determined on a case by case basis.

- CarePlus will render a decision as expeditiously as the member’s health requires but no later than:
  - 72 hours for a expedited pre-service reconsideration
  - 7 calendar days for standard Medicare Part B prescription drug requests
  - 30 calendar days for a standard pre-service reconsideration
    - 60 calendar days for Part B & C payment appeal requests
  - 72 hours for an expedited redetermination (Part D)
  - 7 calendar days for standard redeterminations (Part D)
  - 14 calendar days for Part D payment appeal requests

Note: In some cases, timeframes for standard/expedited pre-service reconsiderations (Part C only) may be extended if either the member or member’s authorized representative requests an extension, or if CarePlus justifies the necessity for additional information and documents that the extension is in the best interest of the member.

Further appeal levels

If the adverse organization/coverage determination is upheld by CarePlus, the member or member’s authorized representative can seek additional review from the subsequent appeal levels.

- For medical care, a treating physician can request an organization determination or a Level 1 appeal on the member’s behalf without being a representative. If the appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, the physician must be appointed as the member’s representative.
- For Part D prescription drugs, the physician or other prescriber can request a coverage determination, Level 1, or Level 2 appeal on the member’s behalf. To request an appeal after Level 2, the physician or other prescriber must be appointed as the member’s representative.
BILLING PROCEDURES

Claims submitted for processing should be in a HIPAA accepted 837I file format and filed electronically under CarePlus Payer ID 95092 through Availity at www.availity.com. If all EDI methods have failed and the provider has contacted their provider services executive for assistance, the provider may then submit their claim on a properly on a UB04 form within the timeframe specified in their contract.

The claim form should include all Medicare required data elements in addition to the fields listed below:

- Patient name
- Patient ID No.
- Patient DOB
- Facility name according to the contract
- Facility tax ID No.
- Plan assigned provider No.
- ICD-10 Diagnosis Code(s)
- Present on admission diagnosis code(s) (POA indicator)
- Facility NPI (field 56)
- Attending NPI and provider name
- Operating NPI and provider name (if applicable)
- Other NPI and provider name (if applicable)
- Revenue codes
- Description of services rendered – CPT-4 codes/HCPC codes/HIPPS codes/MS-DRG
- COB/other insurance information
- Authorized/Pre-cert number or copy of authorization/pre-cert

Providers must submit a corrected claim within 180 days (six months) from the date of service or within the specified time frame outlined in their provider agreement.

Providers are encouraged to submit claims and/or encounters electronically. If you are not currently submitting electronically, contact your provider services executive to get connected.

A “clean” claim is one that no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment. Failure to submit a properly completed “clean” claim will delay processing.

EDI Corrections and Reversals REQUIRED

The 837 TR3 defines what values submitters must use to signal to payers that the inbound 837I contains a reversal or correction to a claim that has previously been submitted for processing. For Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value from the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

- 7 = Replacement of Prior Claim (Used to correct a previously submitted bill with the same TOB/services: i.e. provider bills a 137 to replace a 111 is not acceptable)
- 8 = Void/Cancel of Prior Claim (Used when billing to Void claims for incorrectly submitted claims)
The following coding MUST BE USED:
- Loop 2300
- Segment CLM05-3 = 7
- Segment REF01 = F8
- Segment REF02 = the 13-digit original document number – no dashes or spaces

PAPER Corrections and Reversals REQUIRED

Institutional claims UB-04: Submit with the third digit of Type of Bill as “7” to indicate frequency code 7 – Replacement of Prior Claim (used to correct a previously submitted bill)

The following coding MUST BE USED:

- Enter in condition codes the corresponding code to describe any of the following conditions that apply to the billing period:
  - D0 Changes to Service Dates
  - D1 Changes to Charges
  - D2 Changes to Revenue Codes/HCPCS/HIPPS Rate Code
  - D3 Second or Subsequent Interim PPS Bill
  - D4 Changes in Diagnosis and/or Procedure Code
  - D5 Cancel to Correct HICN or Provider ID
  - D6 Cancel Only to Repay a Duplicate or OIG Overpayment
  - D7 Change to Make Medicare the Secondary Payer
  - D8 Change to Make Medicare the Primary Payer
  - D9 Any Other Change

- Field 64 – Document Control Number (DCN): The document number assigned to the original/Previously submitted bill located on the remit advice or ERA

Effective Oct. 5, 2015, for institutional claims only, when the need for a correction is discovered beyond the claims timely filing limit, a provider must utilize the reopening process using the new bill type frequency submitting with a “Q” in the third position of the Type of Bill (TOB xxQ) to identify them as a reopening and a series of condition codes that can be utilized to identify the type of reopening being requested and reopenings that require good cause to be documented must have a remark/note from the provider. See CMS MLN Matters Numbers: MM8581 “Automation of the Request for Reopening Claims Process.”

For information on where to submit your claims, please refer to the “Key Contact List” at the beginning of this manual.

For skilled nursing facilities: CMS billing requirements for SNFs include, but are not limited to, the following:

- Claims must include the resource utilization group (RUG) with revenue code 022 on the first line of the UB-04 form or its successor.
- HIPPS codes are required for REV Code 002X.
- SNFs with per-diem contracts must submit the revenue code for the per-diem/level of care 191-194 in the format they have been billing.
• The 837 institutional form format is preferred for electronic claim submissions. The UB-04 form (or its successor) may be used when electronic submission is not available.
• SNFs must submit the assessment date with occurrence code 50.

For home health care: CMS billing requirements for home health include, but are not limited to, the following:

• Submission of the home health resource group (HHRG) with revenue code 023
• HIPPS codes are required for REV Code 002X.
• Submission of the treatment authorization code (TAC), which is obtained through the Medicare OASIS system
• Submission of the core-based statistical area (CBSA) where services were rendered (submitted with value code 61)
• Use of an appropriate home health PPS bill type
• Billing each visit on a separate claim line
• Billing each visit with the appropriate CMS-designated revenue and Healthcare Common Procedure Coding System (HCPCS) code combinations
• Billing units appropriate for the description of the HCPCS code (e.g., CMS visit G-codes represent 15-minute increments of service)
• Billing a claim line for non-routine supplies (NRS) when the HHRG indicates NRS were provided
• Billing CMS-required informational Q-codes

For clinical trial: CMS billing requirements for clinical trial/registry/study

Effective for clinical trial/registry/study claims with dates of service on and after Jan. 1, 2014, requires the numeric, eight-digit clinical trial registry number in the electronic claim equivalent, 837I (Loop 2300 REF02 (REF01=P4)) for an 837I claim when a clinical trial claim includes the following:

• Condition code 30
• ICD-10 dx code Z00.6 (in either the primary/secondary positions)
• Modifier Q0 and/or Q1 as appropriate (outpatient claims only)

Effective for clinical trial/registry/study claims with dates of service on and after Jan. 1, 2014, requires the numeric, eight-digit clinical trial registry number in the value amount for paper only value code “D4” on the paper/DDE claim UB-04 (Form Locators 39-41) when a clinical trial claim includes the following:

• Condition code 30
• ICD-10 dx code Z00.6 (in either the primary/secondary positions)
• Modifier Q0 and/or Q1 as appropriate (outpatient claims only)

PRESENT ON ADMISSION (POA) INDICATOR

The provider is required to submit a present-on-admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code on inpatient hospital claims. The requirement mirrors Medicare guidelines.

Present on admission is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, emergency department services,
observation, or outpatient surgery, are considered as present on admission. Hospitals will not receive additional payment by CarePlus when conditions are not present on admission. Instead, they will be paid as if the secondary diagnoses weren't present which are referred to as “never events.”

In addition, consistent with current Medicare policy for noncovered services, CarePlus will not issue payment for a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. CarePlus also will not cover hospitalizations and other services related to these noncovered procedures.

**OVERPAYMENT OF A PROVIDER**

Overpayments include, but are not limited to, situations in which a provider has been overpaid by CarePlus due to an error in processing, incorrectly submitted claims, an incorrect determination that the services were covered, a determination that the covered individual was not eligible for services at the time services were rendered or another entity is primarily responsible for payment of the claim. In the event of an overpayment, CarePlus will notify the provider of the refund amount due in writing via mail, facsimile or email. The provider is responsible for immediately refunding to CarePlus the overpayment amount according to the instructions stated in the written notification. If a refund is not issued, CarePlus may recoup the monies due from any future payments due the provider.

**BALANCE BILLING/MEMBER RESPONSIBILITY**

As a member of a Medicare Advantage plan, CarePlus members are not responsible for balances remaining after payment from the plan is applied to the member's account. The member's sole payment responsibility is for any applicable copayments, coinsurance, deductibles, and noncovered services provided to such members.

Notification that a service is not a covered benefit must be provided to the member prior to the service and be consistent with CarePlus policy, in order for the member to be held financially responsible. CarePlus policy requires that the notification include the date and description of the service, an estimate of the cost to the member for such services, name and signature of the member agreeing in writing of receiving such services, name and signature of the provider, and be in at least 12-point font. Documentation of that pre-service notification must be included in the member’s medical record and shall be provided to CarePlus or its designee upon request, within a timely manner in order to substantiate member appeals.

In the event of a denial of payment for health services rendered to CarePlus members determined not to be medically necessary by the plan, a provider shall not bill, charge, seek payment or have any recourse against member for such services, unless the member has been advised in advanced that the services are not medically necessary and has agreed in writing to be financially responsible for those services pursuant to the above-mentioned CarePlus policy.

**MEDICARE ALLOWABLE FOR UNLISTED SERVICE or PROCEDURE CODE**

Claims filed with an “unlisted” service or procedure code and/or with a procedure code that has no RVU assigned must include documentation of the service provided. The documentation must include a written description of the service and the appropriate medical reports related to the service, including the NDC number for drugs or a copy of the invoice for equipment, if applicable. Unlisted procedure codes are
defined as CPT or HCPCS code descriptions that include one of the following “NOC, NEC, NOS, unlisted, not specified, miscellaneous or special report.” Each claim will be reviewed manually and CarePlus will assign the allowable fee based on established fees for comparable services.

EFT/ERA Enrollment Process to Support Healthcare Claim Payments and Remittance Advices

To enroll in Electronic Funds Transfer (EFT)/ Electronic Remittance Advice (ERA), simply complete the EFT/ERA form and fax the completed form to 1-855-659-7966. You may also mail your completed form to the address below. Copies of the applicable EFT/ERA forms are available on the CarePlus website at: https://www.careplushealthplans.com/careplus-providers/claims. If at any time you have questions regarding the form, please call the Provider Operations inquiry line at 1-866-220-5448; choose Option 1 and then Option 4, Monday through Friday from 8 a.m. to 5 p.m. Eastern time. The provider must contact his or her financial institution to arrange for the delivery of the CORE required minimum CCD+ data elements needed for reassociation of the payment and the ERA. See the Phase III CORE EFT and ERA Reassociation (CCD+/835) rule, version 3.0.0 at www.caqh.org/Host/CORE/EFT-ERA/EFTERA_Reassociation_Rule.pdf.

Note: This new process is only applicable for claims payment and PCP financial distribution, NOT capitation payments.

If applicable, you may mail your completed EFT/ERA authorization form to:

CarePlus Health Plans
ATTN: Provider Operations
11430 NW 20th St., Suite 300
Miami, FL 33172

To complete the ERA enrollment process, you must sign up with Change Healthcare (formerly Emdeon). Please go to https://www.changehealthcare.com/support/customer-resources/enrollment-services/. Under “Medical and Hospital,” click on “ERA Enrollment Forms” and select “ERA Merge Group Provider Setup Form.” Scroll down to the list of ERA Payer Enrollment Forms, in the “Search” box on the right enter CarePlus to bring up the enrollment forms for Professional and Institutional. Complete and submit the ERA Provider Information Form to Change Healthcare via the fax number or email address listed on the form. Note: The CarePlus Health Plans Payer ID for Change Healthcare is 65031.

Providers can receive ERA either directly from Change Healthcare or through a vendor of their choice.

CLAIMS STATUS TELEPHONE QUEUE

CarePlus inbound contacts representatives will be able to assist you in answering inquiries related to billing, status and payment of claims. To ensure short wait times, the representatives will review five accounts per inquiry. The Claims Status Line is 1-866-313-7587. The hours of operation are Monday through Friday, 8 a.m. to 5 p.m. Eastern time.

To better assist you, there is a secure mailbox from which you may retrieve copies of remits, checks and eligibility without having to place a phone call. You may send your requests via email to provider.requests@careplus-hp.com. This email account is checked throughout each business day, and a reply to your correspondence will be sent within 72 business hours. In the event that additional
information is needed to fulfill your request, you may receive a follow-up email message requesting the information.

**Note:** Using this email address with your chosen email solution may provide limited to no security in protecting confidential information. For that reason, please do not include information that you consider to be confidential within email messages sent to this email address. If you must send confidential information, please utilize your organization’s secure email solution or utilize our secure fax option available at 813-463-7809.

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Under the Medicare Advantage (MA) program, MA plans are paid a set premium to cover the costs of health services for their members. The Centers for Medicare & Medicaid Services (CMS) uses demographic and disease data for each member to determine the individual premium. The amount of the premium does not vary based on actual use of health services. This payment system, known as Medicare risk adjustment (MRA), allows CMS to adjust its premium payments to MA plans based on the expected healthcare costs of its members.

The purpose of MRA is to protect member access to services and to protect the financial condition of physicians and other healthcare providers and health plans in a way that is proportionate with the level of healthcare needed by members. CMS more accurately covers a given member’s anticipated health expenditures by taking into account the variation in per capita cost that occurs, based on the health status of the individual. Increased payment accuracy benefits members, physicians and other healthcare providers, MA plans and the Medicare program.

The role of physicians and other healthcare providers
Diagnosis data from physicians and other healthcare providers is used to determine whether an individual member suffers from certain diseases that are expected to lead to higher healthcare costs for that member. CMS requires all health plans to submit Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 claims transactions to CMS for Medicare risk adjustment.

Obligations of MA Plans and Providers

- Medicare Advantage organizations must annually attest to the accuracy of risk adjustment data to CMS.
- As part of the provider participation agreement, by submitting claims to Humana the provider is attesting to the accuracy of the data the provider has submitted, including diagnosis codes.
- Providers have an obligation to correct any erroneous data submitted to Humana.
- Providers are responsible for maintaining an accurate and complete medical record for each Medicare patient.
- Providers are responsible for participating in any Humana medical record reviews or audits related to coding and documentation.

All diagnoses submitted for risk-adjusted payment must meet the following criteria:

- Documented in a medical record based on a face-to-face encounter with an acceptable physician or other healthcare provider type (e.g., physician, hospital)
  Assigned based on dates of service within the relevant data collection period.
- Coded in accordance with standard industry guidelines (ICD-10)
- Based not solely on laboratory or other diagnostic tests, such as radiology reports

In addition to facilitating payment accuracy, good medical record documentation and coding practices, risk adjustment also helps ensure that MA plan members receive the care they need for their health conditions and that they are able to take advantage of disease management and other programs available through their MA plans. To improve medical record documentation and coding practices, physicians and other healthcare providers should consider the following suggestions:
• Use an electronic medical records (EMR) system
• Confirm that all diagnosis codes are included in the claim submission. For professional services, physicians and other healthcare providers should have the capacity to submit 12 diagnosis codes
• Ensure procedure and diagnosis codes on the form are current when using a superbill, encounter sheet or checkout form
• Provide full and accurate documentation – ascertain that diagnoses are supported
• Purchase and use updated coding books or software each year. Make sure the practice management system is kept updated
• Use a certified coder or health information management professional for coding and billing functions

For more information, please contact Jenee Adkins, RHIA, CPC at 813-439-5029 or email jadkins4@careplus-hp.com.
### CAREPLUS COVERED BENEFITS

Please refer to a member’s EOC for a specific description of their benefits as benefits vary by plan.

### PHYSICIAN/PROFESSIONAL OFFICE VISITS

Medical and surgical care in a physician’s or other medical professional’s office.

### ROUTINE PHYSICAL EXAM

Members are covered for an annual comprehensive exam in addition to any Medicare-covered annual exams. Any labs or diagnostic procedures ordered as a result of this exam are covered as separate services according to the member’s plan benefits.

### EMERGENCY/URGENT SERVICES

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

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

**Emergency services** are covered inpatient and outpatient services that are:

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

**Urgently needed services** are covered outpatient services that are provided when a member is temporarily absent from the plan’s service area when the services are medically necessary and immediately required (treatment should not be postponed but it’s not an emergency situation).

- As a result of an unforeseen illness, injury or condition.
- When a member is in the plan’s service area and in need of immediate, medically necessary treatment, but the CarePlus’ provider network is temporarily unavailable or inaccessible, such as after normal business hours or when member’s provider is away from office for extended period, and it is not reasonable to postpone treatment, given the circumstances.

CarePlus will cover emergent/urgent medical care anywhere in the world.

### OUTPATIENT HOSPITAL OBSERVATION

Observation services are outpatient services provided in a hospital setting to determine if admittance to the hospital as an inpatient is necessary or if patient may be discharged. Overnight stays in the hospital may be considered as outpatient observation. Written orders from a state licensed provider is required for coverage of observation services.
HEARING SERVICES (MEDICARE-COVERED)

Covered services include diagnostic hearing and balance evaluations furnished by a physician, audiologist or other qualified provider to determine if medical treatment is required. Prior authorization may be required. Contact CarePlus for additional information.

HEARING SERVICES (ROUTINE)

Coverage for hearing service varies according to the county and the plan. Hearing discounts are described in the VAIS brochure. Please refer members to the number listed below or to CarePlus’ Member Services department for assistance:

Hearing services are provided by HearUSA.
1-800-323-3277

Referral/authorization may be required. Please contact CarePlus for additional details.

HOME HEALTHCARE

Home healthcare services will be covered when beneficiary meets all of the following criteria:

- Confined to home
- Under a plan of treatment with a written physician order established and periodically reviewed by a physician
- Home health agency approved by the Medicare program
- In need of intermittent skilled nursing care, physical therapy, speech therapy, or occupational therapy. Prior authorization may be required. Please contact CarePlus for additional details.

INPATIENT HOSPITAL SERVICES

Inpatient hospital services include all items and medically necessary services that provide appropriate care during a stay in a participating hospital. These services include room and board, nursing care, medical supplies, and all diagnostic and therapeutic services. CarePlus shall be responsible for Part A inpatient care to members who, at the time of disenrollment, are under inpatient care until the time of his/her discharge. Member cost-shares vary by plan, benefit period, and number of days spent in the hospital.

CarePlus shall not be responsible for coverage of Part A inpatient services for inpatient care already being provided at the time of enrollment of a member. The hospital would have to bill either the member’s insurance carrier prior to CarePlus or Medicare directly.

LABORATORY SERVICES

Laboratory services are provided ONLY by Laboratory Corp. of America (Lab Corp).

OUTPATIENT SERVICES

Outpatient services may include the following services provided in an outpatient hospital setting or free-standing facility: therapeutic, radiological and diagnostic procedures and tests such as labs, X-rays, mammograms, colonoscopies, advanced imaging, nuclear medicine, and radiation therapy; surgical services and supplies, wound care, and hyperbaric oxygen treatments; sleep studies; emergency services; as well as mental health care and substance abuse services, including opioid treatment services. Covered
services and member cost-sharing varies by plan. Prior authorization may be required. Please contact CarePlus for additional details.

VISION CARE (MEDICARE-COVERED)

Includes outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration and cataracts, glaucoma and diabetic screenings. Includes one pair of eyeglasses or contact lenses after each cataract surgery. See the EOC or contact CarePlus for specific limitations and exclusions. Prior authorization may be required.

VISION SERVICES (ROUTINE)

Vision services vary according to the county and the plan. Vision discounts are described in the VAIS brochure. Please contact CarePlus for additional details. Please refer member inquiries to CarePlus’ Member Services department.

MEDICARE PART B PRESCRIPTION DRUGS

These drugs are covered under Part B of Original Medicare. Members of CarePlus receive coverage for the following drugs through our plan. Some limitations, restrictions and/or member cost-share may apply.

- Drugs that usually are not self-administered by the patient and are injected or infused in a professional setting
- Drugs that are taken using durable medical equipment (i.e., nebulizers) that were authorized by the plan
- Clotting factors, administered through injections if member has hemophilia
- Immunosuppressive drugs, if the member was enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs if the member is homebound, has a home fracture and a doctor certifies it was related to post-menopausal osteoporosis, and cannot be self-administered
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents (i.e., Epogen®, Procrit®, epoetin alfa, or darbepoetin alfa)
- Intravenous immune globulin for the home treatment of primary immune diseases

MEDICARE PART D PRESCRIPTION DRUGS

COVERED: All plans are required to have formularies that address all medically necessary drugs. Six drug classes of special concern have been specified in which all or substantially all drugs will be on a plan’s formulary: anti-neoplastics, anti-HIV/AIDS drugs, immunosuppressant, anti-psychotics, anti-depressants and anti-convulsants.

NOT COVERED: By law, there are certain types of drugs that Medicare must exclude from Part D: drugs used for anorexia, weight loss or weight gain; fertility drugs; drugs used for the treatment of sexual or erectile dysfunction*; drugs used for cosmetic purposes or hair growth; cough and cold medicines; prescription vitamins and minerals; over-the-counter drugs; and outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale. For your patients that have both Medicare and Medicaid, check
with your state Medicaid program as most programs are continuing to cover all or some of these excluded drugs.

*CarePlus covers some of the excluded erectile dysfunction drugs. Please contact the plan for details. You may access the CarePlus Prescription Drug Guides on our website at https://www.careplushealthplans.com/medicare-plans/2020-prescription-drug-guides.

**MENTAL HEALTHCARE SERVICES – INPATIENT**

Coverage is provided but varies for inpatient mental healthcare provided for patients confined to an acute care facility or a psychiatric facility.

- Acute care facility/general hospital coverage for mental health is limited to 90 days per stay (plus 60 lifetime reserve days available to extend stays until reserve days are exhausted). Once lifetime reserve days are exhausted, all stays are limited to 90 days. There is no limit to the number of stays. Please contact Magellan Healthcare Inc. directly for authorization for psychiatric care.
- Psychiatric facility coverage for mental health is limited to 190 days per lifetime in a Medicare-certified psychiatric facility.

The benefit days used under the Original Medicare program will count toward the 190 day lifetime reserve days when the member enroll in a Medicare Advantage plan. Please contact Magellan Healthcare Inc. directly for authorizations.

**MENTAL HEALTHCARE SERVICES – OUTPATIENT**

Covered services include outpatient group and individual therapy visits and partial hospitalization for treatment of mental illness and/or substance abuse provided by a Medicare-qualified mental health professional. Authorization may be required. Please contact CarePlus for additional details.

**OUTPATIENT REHABILITATION SERVICES**

Covered services include physical therapy, occupational therapy, speech language therapy, cardiac rehab services, intensive cardiac rehab services, pulmonary rehab services and comprehensive outpatient rehabilitation facility (CORF) services. The plan will cover those services which are to be provided by licensed, independently practicing providers who are Medicare certified. Prior authorization may be required. Please contact CarePlus for additional details.

**PERSONAL HOME CARE SERVICES**

Benefit provides short-term assistance with daily living activities (ADLs) to members at home. Qualifying members must reside at home (not in a nursing facility or health facility providing 24/7 care) and require assistance with at least two of the following ADLs: bathing, dressing, toileting, transferring, walking/mobility, or eating/feeding. PCP must refer member to One Homecare Solutions who will authorize services for members who qualify. Please contact CarePlus for details.

**SKILLED NURSING FACILITY SERVICES**

For CarePlus members to receive skilled nursing services, they must need daily skilled nursing or skilled rehabilitation care or both. Members are covered for 100 days each benefit period. The benefit periods
end when the member has not received hospital or skilled nursing care for 60 consecutive days. If the member goes into the hospital after one benefit period has ended, a new benefit period begins. Prior authorization may be required. Please contact CarePlus for additional details.

**AMBULANCE SERVICES**

Covered ambulance services include fixed wing, rotary wing and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health). The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

**DURABLE MEDICAL EQUIPMENT (DME) AND RELATED SUPPLIES**

Examples of covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer and walker. Prior authorization rules may apply. Contact CarePlus for details.

**PROSTHETIC DEVICES AND RELATED SUPPLIES**

CarePlus covers devices that replace body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses. Authorization rules may apply for services. Contact CarePlus for details.

**WIGS**

Most CarePlus plans include a benefit that provides an allowance toward the cost of a wig for members who suffer hair loss as a result of chemotherapy treatments. Please refer to the member’s plan EOC or contact Member Services. Members should be directed to a network DME provider. Prior authorization is required. Contact CarePlus for details.

**KIDNEY/RENAL DIALYSIS FOR END-STAGE RENAL DISEASE**

CarePlus covers dialysis services for members with ESRD either at home or at a facility. The venue for dialysis will be determined by the provider for the member. CarePlus also will cover renal dialysis when the member is temporarily out of the service area. Member cost-sharing for service and supplies varies by plan. Prior authorization rules may apply. Please contact CarePlus for details.

**DIABETES SELF-MONITORING, TRAINING AND SUPPLIES**

Covered services for all members who have diabetes (insulin and noninsulin users) include:

- Blood glucose monitor, blood glucose test strips and lancet devices. Diabetic monitoring supplies have a $0 copayment when obtained from a CarePlus network pharmacy or diabetic supplier. CarePlus covers ACCU-CHEK® by Roche and Trividia products. Non-preferred diabetic monitoring supplies require prior authorization.
- One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts
(not including the noncustomized removable inserts provided with such shoes). Coverage includes fitting. Member cost-share varies by plan.

- Self-management training.
  *Authorization rules may apply. Please contact CarePlus for additional details.

**DENTAL SERVICES (MEDICARE COVERED)***

Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of the teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.
* Referral and authorization rules may apply. Please contact CarePlus for additional details.

**DENTAL SERVICES (ROUTINE)**

Covered dental plan services vary according to the county and the plan. Dental discounts are described in the VAIS brochure. Please contact CarePlus for additional details. Please refer member inquiries to CarePlus’ Member Services department.

**PODIATRY SERVICES (MEDICARE COVERED)**

Medicare covered podiatry services include:

- Foot exams and treatment of injuries and diseases of the feet (such as a hammer toe or heel spurs)
- Treatment for disease-related nerve damage or other medically necessary foot care

Specialist visit copayment varies by plan. Prior authorization may be required. Please contact plan for additional details.

**PODIATRY SERVICES (ROUTINE)**

CarePlus also covers unlimited routine foot care for members with certain medical conditions such as flat feet or other structural misalignments; or, for the removal of corns, warts, calluses; or, for hygienic care. Specialist visit copayment varies by plan. Prior authorization is not required for routine foot care.

**CHIROPRACTIC SERVICES (MEDICARE COVERED)**

Medicare covered chiropractic services are limited to medically necessary manual manipulation of spine to correct subluxation that can be demonstrated by X-ray. Specialist visit copayment varies by plan. Prior authorization may be required.

**CHIROPRACTIC SERVICES (ROUTINE)**

CarePlus also covers up to 12 routine chiropractic visits per year for care/ manual manipulation of the spine. Specialist visit copayment varies by plan. Prior authorization is not required for routine visits.

**TRANSPORTATION SERVICES**

CarePlus provides transportation services through Alivi NEMT Network who will arrange for member transport to plan-approved locations such as network doctor offices, VA clinics, and fitness centers offering SilverSneakers fitness program. One-way trips in excess of 35 miles may require prior authorization. Contact CarePlus for details.
HEALTH AND WELLNESS

CarePlus offers a series of health and wellness education programs and services that address such concerns as fitness, nutrition and smoking cessation. **Note:** Certain programs may be limited or not available for some benefit plans. Please contact CarePlus for further details.

- SilverSneakers® Fitness program
- Meal programs
- Over-the-counter drugs and supplies
- Smoking cessation (available only on special needs plans)

MEDICAL NUTRITION THERAPY

For members with diabetes, renal disease (but not on dialysis), and after a transplant. Authorization rules may apply for services. Contact CarePlus for details.

KIDNEY DISEASE EDUCATION SERVICES

Education to teach kidney care and help members make informed decisions about their care. Prior authorization may be required. Contact CarePlus for details.

PREVENTIVE CARE AND SCREENING TESTS*

CarePlus covers and arranges for appropriate preventive screenings such as:

- Abdominal aortic aneurysm screening
- Adult immunizations
- Annual wellness visit including personalized prevention plan services
- Bone mass measurements
- Cancer screenings (breast, cervical, vaginal, colorectal, prostate)
- Cardiovascular screening
- Diabetes screening
- Diabetes self-management training
- EKG screening (covered as result of IPPE screening once per lifetime)
- Glaucoma screening
- Hepatitis B and C virus screening
- HIV screening
- Initial preventive physical exam (IPPE) (“Welcome to Medicare” physical exam)
- Cardiovascular disease risk reduction visit
- Intensive behavioral therapy for obesity
- Lung cancer screening with low dose computed tomography (LDCT)
- Medical nutrition therapy (for Medicare beneficiaries with diabetes or renal disease)
- Medicare Diabetes Prevention Program
- Obesity screening and therapy
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
- Screening for depression in adults
• Screening for sexually transmitted infections (STIs) and high intensity behavioral counseling to prevent STIs
• Tobacco-use cessation counseling services

* Please note that authorization rules may apply. Please contact CarePlus for additional details.
**Providers may refer to [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html) for the most up-to-date list of Medicare-covered preventive services.

**DIRECT ACCESS WITHOUT AN AUTHORIZATION/REFERRAL**

CarePlus members may receive the following services from network providers without a referral or prior authorization:

• Routine women’s healthcare, which includes breast exams, mammograms (X-rays of the breast), pap test, and pelvis exams. This care is covered without a referral from the member’s PCP only if provided by a plan provider
• Influenza (flu) and pneumonia vaccinations (as long as received from a plan provider)
• Emergency/urgent services
• Renal dialysis when temporarily out of the service area
• Routine chiropractic services up to 12 visits per calendar year provided by plan provider
• Dermatology services, up to five routine office visits per calendar year, as long as the care is provided by plan providers
• Routine podiatry, as long as the care is provided by a plan provider.
• Other supplemental services such as routine dental care, routine vision care, routine hearing services, and routine transportation (one-way trips 35 miles or less) when available as a plan benefit and received from a network provider.

**Note:** CarePlus policy allows for the auto-approval of certain codes that are typically performed in conjunction with another primary service. For example, an authorized evaluation and management services CPT code billed with a diagnostic test which is not included in the referral/authorization. Add-on codes are reimbursable services when reported in addition to the appropriate primary service by the same provider reporting the same federal tax identification number.

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PARTICIPATING PROVIDER GRIEVANCES AND REQUESTS FOR CLAIMS RECONSIDERATIONS

Participating providers may submit a complaint to CarePlus to express dissatisfaction with the plan and to request reconsiderations of a claim denial or payment amount.

Requests for Review of Denied Claims: Participating providers may request a review of service or claim payment denials by the Plan. To obtain a review, providers must telephone CarePlus provider services queue at 1-866-313-7587, the number that is listed on the back of the Member’s ID card, or send a written request to the CarePlus Claims address at P.O. Box 14697, Lexington, KY 40512-4697.

Provider Claims Reconsideration Process: If, upon receipt of an initial claim determination from CarePlus via electronic or paper Remittance Advice, the provider disagrees with the determination made by CarePlus and would like to request a reconsideration/reopening of the issue, providers may do so by contacting CarePlus via written correspondence to the mailing address:

CarePlus Correspondence
P.O. Box 14697
Lexington, KY 40512-4697

When sending in a written request for reconsideration/reopening the following information must accompany the request: provider name and tax ID, member name and identification number, date of service, relationship of the member to the patient, claim number, name of the provider of services, charge amount, payment amount, and a brief description of the basis for the contestation. In addition, be sure to include any relevant supporting documentation (medical records, copy of invoice, etc.).

If a provider has a grievance regarding any aspect of CarePlus operations, the provider should first contact their designated provider services executive to discuss the matter. In the event a provider wishes to submit a formal grievance or request a second-level review of a previously reviewed claim denial or payment dispute, the provider must document in writing the circumstances and forward to his or her designated provider services executive at:

CAREPLUS HEALTH PLANS INC.
Attention: Provider Operations department
11430 NW 20th St., Suite 300
Miami, FL 33172

The letter will be reviewed by the provider operations department and other plan departments as required in order to make a determination. A response will be sent within 60 days after receipt of the letter.

Note: The above provisions of this section are to be considered as separate and distinct from the arbitration provisions set forth in provider’s Agreement.

Important Note for Delegated Providers:
Claim issues or provider disputes must be submitted directly to the delegated entity and reviewed by the delegated entity’s claim resolution process. For additional details, please refer to the delegated entity you are affiliated to and/or your participating provider agreement with said entity.
CLAIMS AUDIT

CarePlus reserves the right to audit all claims, itemized bills and applicable medical records documentation for billing appropriateness and accuracy.

Payment Integrity Review

CarePlus operates a payment integrity review program to facilitate accurate claim payments and detect/prevent fraud, waste and abuse. CarePlus will review claim payments within 24 months from the last date of claim payment, except in cases of fraud or waste and abuse.

CarePlus will conduct select medical record review on pre-payment and post-payment bases. The pre and post payment review processes will be requested based on Medicare criteria and Medicare and AMA coding requirements (an example of items review include but are not limited to, records to substantiate coding and charges, incorrect code selection, unit errors, duplicate charges, codes not supported by the diagnosis, items not separately payable, etc.). These reviews will confirm that the most appropriate and cost-effective supplies were provided and that the records document the medical necessity, setting and level of service that was provided to the patient is supported by the records.

The Treatment, Payment and Health Care Operations (TPO) exception under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR 164.506) allows the release of medical records containing protected health information between covered entities without additional authorization for the payment of health care claims. Health care professionals who believe that an additional release authorization for this review is necessary should obtain from CarePlus members their authorization for release of the medical records to CarePlus, along with the health care professional’s consent-to-treatment forms, or the requirement will be waived if permitted by law.

Below you will find a description pre-payment, post-payment and dispute process of the CarePlus payment integrity program.

- Pre-payment review, CarePlus (or its designee) will request medical records to document and support the codes and charges billed. An initial request letter will be sent requesting the medical records be submitted within 45 days of the request. Three additional attempts will be made to obtain records; eight (8) weeks from the initial request date a remittance advice will be sent to the provider denying the claim due to lack of medical records. Records that are received within the time frame will be reviewed and a remittance advice will be sent to the provider and the claim adjusted accordingly.

- Post-payment review, CarePlus (or its designee) will request medical records to document and support the codes and charges billed.

  - Desk reviews, an initial request letter will be mailed to the provider requesting that the records be provided within 30 days from the date of the letter. A second letter will be mailed to the health care provider, allowing an additional 30 days to respond. A final notice will be sent to the provider allowing an additional 30 days from the date of the letter. A refund request letter will be sent to the provider if the records are not received within 30 days of the final request for medical records request. The provider will have 45 days from the date on the refund request letter to send a refund check before the paid amount of the claim is recouped due to medical records not received. Review of medical records received within the time frame will be completed, if an overpayment is found a refund request will be sent, if a refund is not
received within 45 days the paid amount of the claim will be recouped. If an underpayment is found, notice will be sent to the provider to submit a corrected claim for additional payment.

- On-site review, CarePlus or the designee will contact the health care professional’s review representative to schedule an on-site review. The health care professionals are asked to respond to a scheduling request within 30 days of receipt of the request and schedule the review on a mutually agreed date and time and submit an itemized bill prior to the visit, if requested. The health care providers should respond to a scheduling request within 30 days of receipt of the request and schedule the review on a mutually agreed date and time. If a scheduled date is not confirmed by the provider within 30 days of the initial request, CarePlus or the designee will attempt to contact the facility via phone, email or letter. If there is still no response, two additional attempts will be made (30 days apart). If CarePlus or its designee is still unsuccessful at scheduling a date for the post-pay on-site review after these attempts, a denial may be issued for all review-related claims. Once the review has been scheduled, the denial will be reversed and the claims will be processed, providing that the scheduled date is within applicable contractual and federal guidelines.

CarePlus or the designee will notify the health care professional of the review results of the on-site review via letter or by conducting exit conferences within 30 days from the date CarePlus or its designee completes the review (or on an alternative agreed-upon date).

- Disputes, providers not in agreement with the explanation or findings may dispute in writing with the reason for the dispute and complete medical records for the services being disputed. CarePlus will not accept a payment integrity dispute after 12 months from the final notice of request for medical records related to a pre or post payment medical records denial. Notwithstanding the foregoing, all disputes must be submitted within the specific time frames set out in any applicable contract or as otherwise required by applicable federal law. If you do not submit a written request to dispute the review findings or if your request is not received within the required time frame, the original review findings will be final.

Disputes should be sent to:

CarePlus Health Plans Inc.
Attention: Operational Audit Department
4925 Independence Parkway, Suite 300
Tampa, FL 33634

**Interim Bills:** Interim bills will not be accepted for MS-DRG or APC Claims. In order to properly adjudicate a claim paid on a Medicare Allowable basis, the patient must be discharged.

**Itemized Statements:** CarePlus may require itemized statements as deemed necessary and appropriate.

**Note:** CarePlus may contract with vendors to conduct audits on the plan’s behalf.
COORDINATION OF BENEFITS AND SUBROGATION

As a participating provider with CarePlus we require that you notify the plan of any third-party information you may have received and that you assist the plan in complying with the Medicare secondary payer rules. In addition, if you are notified of a Medicare set-aside plan please notify the plan immediately.

CarePlus is subject to the rules and regulations as defined by the Social Security Act and the CMS Medicare Secondary Payment (MSP) provision. Medicare Advantage organizations are allowed four provisions in which Medicare is considered a secondary payer.

- Employer Group Health Plans (EGHP) and Large Group Health Plans (LGHP)
- Liability Insurance Plans
- No-fault Insurance Plans
- Workers’ Compensation Plans (WC)

**Employer Group Health Plans (EGHP)**
**Policy:** Coverage under a health plan offered by an employer in which a Medicare beneficiary is covered as:

- An employee (age 65 or older) or
- As a dependent under another subscriber (of any change) covered under such plan

**Note:** Medicare is the secondary payer for beneficiaries assigned to Medicare under the ESRD benefit for up to 30 months beginning when the individual becomes eligible for Medicare if the beneficiary was not otherwise eligible due to age or disability

**Liability Insurance and No-fault Insurance**

**Policy:** Types of liability include, but are not limited to automobile liability, malpractice, homeowner’s liability, product liability, and general casualty insurance. Medicare is considered the secondary payer to all liability and no-fault insurance providers.

**Workers’ Compensation (WC)**

**Policy:** Medicare does not coordinate benefits with Workers Compensation payers. Workers’ Compensation assumes full liability for the payment of items and services related to a claim meeting their coverage requirements.

When a member has coverage, other than with CarePlus, which requires or permits coordination of benefits from a third party payer in addition to CarePlus, CarePlus will coordinate its benefits with such other payer(s). In all cases, CarePlus will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, CarePlus will pay the lesser of: (i) the amount due under the prevailing agreement; (ii) the amount due under the prevailing agreement less the amount payable or to be paid by the other payer(s); or (iii) the difference between allowed billed charges and the amount paid by the other payer(s). In no event, however, will CarePlus, when its plan is a secondary payer, pay an amount, which, when combined with payments from the other payer(s), exceeds
the rates set out in the prevailing agreement; provided, however, if Medicare is the primary payer, CarePlus will, to the extent required by applicable law, regulation or Center for Medicare/Medicaid Services (CMS) Office of Inspector General (OIG) guidance, pay facility an amount up to the amount CarePlus would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

**Recovery:** Facility and CarePlus agree to use reasonable efforts to determine the availability of other benefits, including other party liability, and to obtain any information or documentation required by CarePlus and facility to facilitate coordination of such other benefits. Upon request by CarePlus, facility will provide CarePlus with a copy of any standard facility forms used to obtain the necessary coordination of benefits information.

**Payment Adjustment:** Facility and CarePlus agree that retroactive adjustment to the payment including but not limited to claims payment errors, data entry and incorrectly submitted claims shall be submitted to recovery of over/under payment process.
Forms

Spanish versions of the forms can be made available upon request
Request for Provider Crisis Contact/Location Information

Please complete and submit this form if a disaster or other crisis requires evacuation of your area and/or relocation of your office(s). CarePlus’ Member Services will use this information to assist CarePlus-covered patients in locating their physicians and other health care providers during emergency situations.

**Note to provider groups:** A separate form should be completed for each individual physician/provider in the group if the information is not the same for everyone in the group.

<table>
<thead>
<tr>
<th>Effective date of relocation</th>
<th>Physician’s/provider’s name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Tax ID no.</td>
<td></td>
</tr>
</tbody>
</table>

**Original office physical address prior to disaster**

<table>
<thead>
<tr>
<th>Street address:</th>
<th>City and state:</th>
<th>Office phone number:</th>
<th>Fax number:</th>
</tr>
</thead>
</table>

**Relocation office physical address**

<table>
<thead>
<tr>
<th>Temporary</th>
<th>Permanent</th>
</tr>
</thead>
</table>

| Street address: | City and state: | Office phone number: | Fax number: | ZIP code: |
|----------------|-----------------|----------------------|------------|

**Office contact name (office administrator)**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Office or cell phone number:</th>
<th>Email address:</th>
</tr>
</thead>
</table>

**Relocation billing address**

<table>
<thead>
<tr>
<th>Temporary</th>
<th>Permanent</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street address/P.O. box:</th>
<th>City and state:</th>
<th>Phone number:</th>
<th>ZIP code:</th>
</tr>
</thead>
</table>

**Current email address**

**Claims payment to**

<table>
<thead>
<tr>
<th>Check one: Group</th>
<th>Individual</th>
</tr>
</thead>
</table>

**Has the address changed for claims payment checks?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Permanent</th>
<th>Temporary</th>
</tr>
</thead>
</table>

**New claims payment address (if applicable)**

<table>
<thead>
<tr>
<th>Street address/P.O. box:</th>
<th>City and state:</th>
<th>ZIP code:</th>
</tr>
</thead>
</table>

**National Provider Identifier (NPI) no.**

**Unique Physician Identification no. (UPIN)**

**Medicare no.**

**Medicaid no.**

**Drug Enforcement Administration license no.**

**State medical license no.**

Please submit this form to CarePlus’ Provider Operations Department using one of the following methods:

<table>
<thead>
<tr>
<th>Mail</th>
<th>Fax</th>
<th>Provider Service Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention: Provider Operations Dept. 11430 NW 20th St., Suite 300 Miami, FL 33172</td>
<td>786-336-8674</td>
<td>Please scan the form and email it to your assigned provider service executive.</td>
</tr>
</tbody>
</table>
Health Services Referral Request

The information transmitted herein is intended only for the person or entity to which it is addressed and may contain confidential material. If you receive this document in error, please contact the sender and delete or destroy the material/information.

☐ Standard (Routine) Request
☐ Expedited Request – All expedited requests must meet this Centers for Medicare & Medicaid Services definition: The health care professional or member believes the member’s health, life or ability to regain maximum function can be jeopardized if the standard 14 calendar-day time frame is applied. Please include clinical documentation to support expedited requests.

Please complete this form fully and submit clinical notes supporting the medical necessity for the requested service(s). Send it, with a cover sheet, to the appropriate fax number listed at the bottom of this form.

REQUEST DATE _______________ APPT. DATE ____________ APPT. TIME ______________ SENDER’S NAME __________________________
PHONE (____) ______________ FAX (____) _______________ REQUESTING PROVIDER (PCP □ SPECIALIST □) ______________
PROVIDER ID _______ Tax ID: NPI: __________________________
PATIENT’S LAST NAME ___________________ FIRST NAME __________________ PHONE ___________________ DATE OF BIRTH ________________

IS REFERRAL RELATED TO AN ACCIDENT? YES ☐ NO ☐ If yes, please specify (circle): Auto / Work comp / Other

RENDERING PHYSICIAN/PROVIDER ID#: HEALTH CARE FACILITY PROVIDER ID: __________________________
PHYSICIAN/PROVIDER NAME: HEALTH CARE FACILITY NAME: __________________________
TAX ID: TAX ID: __________________________
NPI #: NPI #: __________________________
ADDRESS: ADDRESS: __________________________

PHYSICIAN/PROVIDER PHONE: (____) INPATIENT REQUEST: ☐
PHYSICIAN/ PROVIDER FAX: (____) OUTPATIENT REQUEST: ☐

INITIAL: ☐ FOLLOW UP: ☐ NUMBER OF VISITS REQUESTED ______

ICD-10 DIAGNOSIS CODE(S)/DESCRIPTION PROCEDURE CODE(S)/DESCRIPTION QUANTITY
1. 1. __________________________
2. 2. __________________________
3. 3. __________________________
4. 4. __________________________
5. 5. __________________________

CAREPLUS HEALTH PLANS FAX NUMBERS
BROWARD & PALM BEACH COUNTIES MIAMI-DADE COUNTY ALL OTHER COUNTIES
1-866-852-2678 1-888-790-9999 1-888-634-3521

1621FL1116/H1019_HSPrvdReferralReqForm2016
ADMISSION NOTIFICATION FORM
PHONE # 800/201-4305 FAX # 866/229-1538 (24 hours)
AFTER HOURS PH # 800/201-4305

Request Date:_______________

Hospital: _____________________________________________________________________ PROV # ______

Patient’s Name: ________________________________________________________________

CarePlus I.D. #: ________________________________________________________________

Admit Source: (Please choose one)
- Admission after ER: __________
- Direct admission from PCP/Specialist office: __________
- Admitted after out patient procedure or out pt surgery: __________

Type of Admission ordered by MD: (Please Circle one) FULL   OBS

Patient’s DX: __________________________________________________________________
______________________________________________________________________________

Adm Phy: ___________________________ Phone: ___________________________

Admission Date: _________________ Admission Time: ________________

Requested by: ________________________________

Phone number: ______________________ Fax: ____________________________

Comments: ____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

PLEASE ATTACH FACESHEET            UPDATED 4/8/13
Glucose Meter/Supplies Order Form

Patient Name: __________________________________________ Date: ________________

Patient ID#: ______________________________ DOB: ______________________________

Address: __________________________________________________________________________

City: __________ State: ___ Zip: ______ Phone: ________________________________

Please indicate the preferred blood glucose meter below:

- [ ] True Metric® Air
- [ ] Accu-Chek® Aviva
- [ ] Accu-Chek® SmartView
- [ ] Accu-Chek® Guide

Please circle requested information below:

<table>
<thead>
<tr>
<th>Meter needed?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test strips – quantity</td>
<td>#50</td>
<td>#100</td>
</tr>
<tr>
<td>Lancets – quantity</td>
<td>#100</td>
<td>Other ________</td>
</tr>
<tr>
<td>Test frequency – number of times patient tests per day</td>
<td>QD</td>
<td>BID</td>
</tr>
<tr>
<td>Refills</td>
<td>PRN</td>
<td>Other ________</td>
</tr>
</tbody>
</table>

Physician Name (please print or type): ___________________________ NPI: _____________________

Physician Signature: __________________________________________ Phone: ____________________

Fax: ________________________

Note: The following information must be confirmed by the member’s physician:
- The patient who will be provided with a no-cost glucose meter has been diagnosed as having diabetes and is capable of being trained to use the particular device prescribed in an appropriate manner.
- In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to ensure that the intended effect is achieved. This is permissible if the record is properly documented by the patient’s physician.

By providing the information requested and signing this form, you are confirming the information noted above. For questions regarding fax transmittal, call 1-800-526-1490. Please allow 10 days for delivery.
CONFIDENTIAL - DO NOT PHOTOCOPY - DO NOT PLACE WITH MEDICAL RECORD

MEMBER OCCURRENCE REPORT
PREPARED FOR QA PURPOSES AND FOR LEGAL COUNSEL IN ANTICIPATION OF LITIGATION
COMPLETE ALL APPLICABLE INFORMATION

Hu-51 9/2010

<table>
<thead>
<tr>
<th>Date of Occurrence</th>
<th>Time</th>
</tr>
</thead>
</table>

Provider/Facility Information Related to Occurrence (if available, please fill out information below):

Provider Name

If physician, specialty

Address

City  State  Zip

Phone  Physician ID #

Location of Occurrence / Facility Name

If Humana Facility, Facility ID #

Address of Facility

City  State  Zip

Name

Address

City  State  Zip

DOB

Sex  ☐ Male  ☐ Female

Phone

Other Phone

Member ID Number

Member Type / LOB

Member Billing Ledger (If known)

Primary Caregiver Diagnosis

Medical Treatment Required  _select_

If member hospitalized, name of facility

Date admitted

Name of Provider rendering care

Phone

City  State  Zip

_____ select_____   _____ select_____   Body Part (Indicate Right, Left, Upper, Lower)

Describe Facts of Occurrence (If typed, press enter at the end of each line.)

Person(s) who witnessed or were directly involved in the occurrence other than the person listed above

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City  State  Zip</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City  State  Zip</td>
<td></td>
</tr>
</tbody>
</table>

Phone #  Other #

Reported By

Name

Title

Date

In addition to Risk Management, Occurrence was reported to the following department(s):

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

FORWARD TO HUMANA RISK MANAGER/DESIGNEE UPON COMPLETION
Consent for Release of Protected Health Information (PHI)

This form is used to authorize consent for CarePlus to communicate PHI to the person(s) or organization below.

**Member information** (person whose information will be released):

Name: ____________________________ Date of birth: ___________ Month / Day / Year

Address: ___________________________ Street __________________ City __________________ State __________________ ZIP Code __________________

Member ID: ________________________ Telephone number (with area code): ______________________

☐ Home ☐ Cell*

I understand that this authorization will allow CarePlus and its affiliates to use or disclose any protected health information CarePlus and its affiliates maintain, including mental health, HIV, health status or substance abuse records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.

This information may be disclosed to, and used by, the following individuals or organizations:

Name: ____________________________ Date of birth: ___________ Relationship: __________________

Address: ___________________________ Street __________________ City __________________ State __________________ ZIP Code __________________ Phone: __________________

☐ Home ☐ Cell*

Name: ____________________________ Date of birth: ___________ Relationship: __________________

Address: ___________________________ Street __________________ City __________________ State __________________ ZIP Code __________________ Phone: __________________

☐ Home ☐ Cell*

I understand:

* This consent is valid until I cancel it. I can cancel my consent at any time by submitting a written notice to CarePlus. If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, CarePlus cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

I am not required to sign this consent and CarePlus cannot base decisions regarding treatment or payment on whether I sign it.

Signature of Member or Legal Representative: ____________________________

☐ Member ☐ Legal Representative

Date: ____________________________

Please note: Legal representatives must attach copies of authorizations as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will, or guardianship papers.

After you complete and sign the form, please fax it to 1-855-819-8679. OR, if you prefer, mail your completed form to: CarePlus Health Plans, Inc., PO Box 14733, Lexington, KY 40512-4642.

* By giving your cell phone number, you give CarePlus permission to make calls to your cell

** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care information

If you have any questions, please call Member Services department at 1-800-794-5907. TTY users should call 711. From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.
Appointment of Representative

Name of Party

Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative
To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual,______________________, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation
Date

Street Address
Phone Number (with Area Code)

City
State
Zip Code

Email Address (optional)

Section 2: Acceptance of Appointment
To be completed by the representative:
I,______________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.
I am a / an ____________________
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative
Date

Street Address
Phone Number (with Area Code)

City
State
Zip Code

Email Address (optional)

Section 3: Waiver of Fee for Representation
Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)
I waive my right to charge and collect a fee for representing ____________________ before the Secretary of HHS.

Signature
Date

Section 4: Waiver of Payment for Items or Services at Issue
Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably have been expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature
Date
Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, “Petition to Obtain Representative Fee” elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative’s fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to file Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you’ve been discriminated against. Visit https://www.cms.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0930-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1696 (Rev 08/18)
Grievance or Appeal Form

If you have a grievance or appeal related to your CarePlus plan or any aspect of your care, we want to hear about it. You can use this form to tell us what happened and let us know how we can help. Please provide complete information, so we can address your issue.

This form, along with any supporting documents (such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your doctor), may be sent to us by mail or fax:

**Address:** CarePlus Health Plans  
11430 NW 20th Street, Suite 300  
Miami, Florida 33172  
Attn: Grievance/Appeals Department

**Fax Number:** 1-800-956-4288

If you need assistance with this form, please call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.

1. **Who is the member?**

<table>
<thead>
<tr>
<th>Member name (first and last)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CarePlus member ID number</td>
</tr>
<tr>
<td>Street address</td>
</tr>
<tr>
<td>State</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

2. **What is the issue?**

For a specific medical service or medication, please provide the details below:

<table>
<thead>
<tr>
<th>Medical service/medical equipment or medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider (Physician, Facility, Prescriber)</td>
</tr>
<tr>
<td>Provider phone number (with area code)</td>
</tr>
</tbody>
</table>

Is this a request for reimbursement? □ Yes □ No
*If yes, please include a copy of the bill, receipt or proof of payment (receipts).

<table>
<thead>
<tr>
<th>Service date(s) (MM/DD/YY)</th>
<th>Claim number (if you have one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*NA if care has not been received</td>
<td></td>
</tr>
</tbody>
</table>

H1019_GRVAPLForm2020_C
2 What is the issue? (Continued)

What should we know about this issue? Please be as specific as possible about what happened and who was involved. Include any dates of service or contact with CarePlus employees, healthcare providers or pharmacies. If you run out of room, feel free to write on the back or add an extra page.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

What additional information can you share? Please attach copies of any supporting information or documents that we should review, such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your provider.

What documents have you attached?

☐ Explanation of Benefits  ☐ Receipts (Proof of Payment)
☐ Medical bill(s)  ☐ Letter from your provider
☐ Medical records  ☐ Other ____________________

Does your appeal need to be expedited? If you or your physician/prescriber believe that waiting for a standard decision (7 calendar days for a Part B/Part D prescription drug appeal or 30 calendar days for a medical pre-service/equipment appeal) could seriously harm your life, health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician or prescriber indicates that waiting for a standard decision could seriously harm your health, we will automatically give you a fast decision. If you do not obtain your physician or prescriber’s support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to review for a service or drug you already received.

H1019_GRVAPLForm2020_C
☐ Please check this box if you believe you need an expedited decision within 72 hours. If you have a supporting statement from your physician or prescriber, attach it to this request.

3 Do you need to appoint a representative?

Skip this section if you are the member acting on behalf of yourself.

If you are not the member and aren't sure if you're authorized to work with CarePlus on the member's behalf, please complete the Appointment of Representative (AOR) Form CMS-1696, which can be found on the CarePlus' website at <https://www.careplushealthplans.com/members/drug-coverage-determination> or requested by contacting Member Services at 1-800-794-5907; TTY: 711. Both you and the member must sign and complete the AOR Form. If you are already legally authorized to act as the member's representative under state law, please attach the appropriate documentation so we can review (for example: court appointed guardian, Durable Power of Attorney, health care proxy, etc.).

4 Sign and Submit

<table>
<thead>
<tr>
<th>Member Signature (or physician/prescriber) (optional)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Printed Name (or physician/prescriber)</td>
<td></td>
</tr>
</tbody>
</table>

OR

<table>
<thead>
<tr>
<th>Authorized Representative Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Only if you filled out the AOR form or attached other legal documentation)</td>
<td></td>
</tr>
<tr>
<td>Authorized Representative Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

Thanks for taking the time to inform us of this issue. We’ll be in touch with you if we have any questions, and we’ll get back to you as soon as we complete our review of the issue.
IMPORTANT!

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. CarePlus complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CarePlus, there are ways to get help.

- You may file a complaint, also known as a grievance, with:
  CarePlus Health Plans, Inc. Attention: Member Services Department.
  11430 NW 20th Street, Suite 300. Miami, FL 33172.
  If you need help filing a grievance, call 1-800-794-5907 (TTY: 711). From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.

- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).


Auxiliary aids and services, free of charge, are available to you.
1-800-794-5907 (TTY: 711)

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.
1-800-794-5907(TTY:711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語資協助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resewewa sevis ed pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d’aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

ગુજરાતી (Gujarati): નિચેનો નંબર આપ્યાંને સુધી મુલાખત મારે આપે એક ઓળ્ખ માંસાર અર્થ હોય કે કેવી રીતે?

ภาษาไทย (Thai): การปรึกษาที่เกี่ยวข้องคุณจะได้รับฟรี โปรดติดต่อที่หมายเลขด้านล่าง.

Diné Bizaad (Navajo): Wó dahí béesh bee hani’i bee wolta’i gih bich’i’ hódíílíní éí bee táá jíik’eh saad bee áka’amida’í wó déc ník’a’goowól.

العربية (Arabic):

H1019_GRVAPLForm2020_C
REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address: 11430 NW 20th Street, Suite 300
         Miami, FL 33172
         Attention: Pharmacy Department

Fax Number: 1-800-310-9071

You may also ask us for a coverage determination by phone at 1-800-794-5907 or through our website at www.careplushealthplans.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee’s Information

<table>
<thead>
<tr>
<th>Enrollee’s Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee’s Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone</td>
<td>Enrollee’s Member ID #</td>
</tr>
</tbody>
</table>

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

| Requestor’s Name |
| Requestor’s Relationship to Enrollee |
| Address |
| City | State | Zip Code |
| Phone |

Representation documentation for requests made by someone other than enrollee or the enrollee’s prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

H1019_PHACDRequestForm2020_C
Type of Coverage Determination Request

☐ I need a drug that is not on the plan’s list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan’s list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan’s limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

*NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached “Supporting Information for an Exception Request or Prior Authorization” to support your request.

Additional information we should consider (attach any supporting documents):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber’s support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).

Signature: _____________________________ Date: _____________________________
Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber’s supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

<table>
<thead>
<tr>
<th>Prescriber’s Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Office Phone</td>
</tr>
<tr>
<td>Prescriber’s Signature</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis and Medical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication:</td>
</tr>
<tr>
<td>Date Started:</td>
</tr>
<tr>
<td>☐ NEW START</td>
</tr>
<tr>
<td>Height/Weight:</td>
</tr>
<tr>
<td>Drug Allergies:</td>
</tr>
</tbody>
</table>

DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. (If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)

<table>
<thead>
<tr>
<th>Other RELEVANT DIAGNOSES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Code(s)</td>
</tr>
</tbody>
</table>

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

<table>
<thead>
<tr>
<th>DRUGS TRIED</th>
<th>DATES of Drug Trials</th>
<th>RESULTS of previous drug trials</th>
</tr>
</thead>
<tbody>
<tr>
<td>(if quantity limit is an issue, list unit dose/total daily dose tried)</td>
<td>FAILURE vs INTOLERANCE (explain)</td>
<td></td>
</tr>
</tbody>
</table>
What is the enrollee’s current drug regimen for the condition(s) requiring the requested drug?

<table>
<thead>
<tr>
<th>DRUG SAFETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any <strong>FDA NOTED CONTRAINDICATIONS</strong> to the requested drug?</td>
</tr>
<tr>
<td>Any concern for a <strong>DRUG INTERACTION</strong> with the addition of the requested drug to the enrollee’s current drug regimen?</td>
</tr>
<tr>
<td>If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient?</td>
</tr>
</tbody>
</table>

**OPIOIDS – (please complete the following questions if the requested drug is an opioid)**

<table>
<thead>
<tr>
<th>What is the daily cumulative Morphine Equivalent Dose (MED)?</th>
<th>mg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of other opioid prescribers for this enrollee?</td>
<td>☐ YES ☐ NO</td>
</tr>
<tr>
<td>If so, please explain.</td>
<td></td>
</tr>
<tr>
<td>Is the stated daily MED dose noted medically necessary?</td>
<td>☐ YES ☐ NO</td>
</tr>
<tr>
<td>Would a lower total daily MED dose be insufficient to control the enrollee’s pain?</td>
<td>☐ YES ☐ NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RATIONALE FOR REQUEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ <strong>Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure</strong> [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]</td>
</tr>
<tr>
<td>☐ <strong>Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change</strong> A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering), etc.</td>
</tr>
<tr>
<td>☐ <strong>Medical need for different dosage form and/or higher dosage</strong> [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]</td>
</tr>
<tr>
<td>☐ <strong>Request for formulary tier exception</strong> Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]</td>
</tr>
</tbody>
</table>
☐ Other (explain below)

Required Explanation


Request for Redetermination of Medicare Prescription Drug Denial

Because we, CarePlus, denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address: Fax Number:
11430 NW 20th Street, Suite 300 1(800) 956-4288
Miami, FL 33172

You may also ask us for an appeal through our website at www.careplushealthplans.com. Expedited appeal requests can be made by phone at 1(800)794-5907.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

<table>
<thead>
<tr>
<th>Enrollee’s Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee’s Name</td>
</tr>
<tr>
<td>Enrollee’s Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Phone</td>
</tr>
<tr>
<td>Enrollee’s Plan ID Number</td>
</tr>
</tbody>
</table>

Complete the following section ONLY if the person making this request is not the enrollee:

<table>
<thead>
<tr>
<th>Requestor’s Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requestor’s Name</td>
</tr>
<tr>
<td>Requestor’s Relationship to Enrollee</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Phone</td>
</tr>
</tbody>
</table>

Representation documentation for appeal requests made by someone other than enrollee or the enrollee’s prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.
**Prescription drug you are requesting:**

Name of drug: ___________________ Strength/quantity/dose: ___________________

Have you purchased the drug pending appeal?  ☐ Yes  ☐ No

If “Yes”:
Date purchased: __________ Amount paid: $ ______________ (attach copy of receipt)

Name and telephone number of pharmacy: ________________________________

**Prescriber’s Information**

Name: ________________________________

Address: ________________________________

City __________________ State ______ Zip Code ______

Office Phone: __________________ Fax: __________________

Office Contact Person: ________________________________

**Important Note: Expedited Decisions**

If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber’s support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS

If you have a supporting statement from your prescriber, attach it to this request.

**Please explain your reasons for appealing.** Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

________________________________________

________________________________________

________________________________________

Signature of person requesting the appeal (the enrollee, or the enrollee’s prescriber or representative):

________________________________________

Date:

H1019_GRVAPLRedeterminationReqForm2018_ C
CarePlus is an HMO plan with a Medicare contract. Enrollment in CarePlus depends on contract renewal.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-794-5907 (TTY: 711).
SAMPLE
EMERGENCY EVACUATION PLAN

____________________ [Employing Office] __________________

____________________ [Location] __________________

____________________ [City, State, Zip] __________________

This plan was prepared by:

Name: ____________________________  Title: ____________________________

City, State, Zip: ____________________________

Signature: ____________________________  Date: ____________________________
INTRODUCTION
During certain emergency conditions, it may be necessary to evacuate a building. Examples of emergencies where evacuation may be required include: smoke/fire, gas leak, bomb threat, power outages, extreme weather, etc. Pre-planning and rehearsal are effective ways to ensure that building occupants recognize the evacuation alarm and know how to respond. Practicing an evacuation during a non-emergency drill provides training that will be valuable in an emergency situation.

This plan is for the safety and well-being of the employees of _______________________. It identifies necessary management and employee actions during fires and other emergencies. Education and training is provided so that all employees know how and understand the contents of the Emergency Evacuation Plan.

LOCATION OF PLAN
Each employee of this office has been provided a copy of this plan. A copy will also be maintained at _____________________________________________.

Any questions concerning this plan should be directed to plan preparer, ________________ _______________________.

PERSONNEL RESPONSIBILITIES DURING EVACUATION PROCEDURES
• Evacuation and Reporting Emergencies
An employee, upon discovering a fire, or any type of emergency, shall immediately notify other employees in the area of the situation and sound an appropriate alarm. The employee is to immediately evacuate the building via the shortest and safest route. DO NOT USE ELEVATORS. Employees must be aware and ready to assist patients with special needs (i.e., hearing, or sight-impaired, on crutches, in a wheelchair). As soon as safely as possible, the situation shall be reported to the appropriate outside emergency personnel.

EMERGENCY TELEPHONE NUMBERS
Police and/or Fire Department ................................................................. 911
Medical Emergencies ............................................................................. 911
Miami-Dade Police Non Emergency ............................................ (305) 476-5423
American Association of Poison Control Centers ....................... (800) 222-1222
Miami Animal Control Center ....................................................... (786) 594-1189
Within this office, the following personnel have the duty to ensure that outside emergency personnel have been contacted. They are responsible for coordinating with outside emergency personnel on the scene and providing directions to the site of the emergency. These personnel are listed in descending order of availability:

1. ___________________________  ___________________________
   Name                        Phone

2. ___________________________  ___________________________
   Name                        Phone

3. ___________________________  ___________________________
   Name                        Phone

- **Accounting for Employees**

After exiting the building, all employees are to assemble for roll call at the following location:

________________________________________________________________________

The following employees are responsible for ensuring that employees comply with this requirement, conducting a roll call and reporting to outside emergency personnel the last known location of any missing employees. Those responsible for reporting are listed in descending order of availability:

1. ___________________________
   Name

2. ___________________________
   Name

3. ___________________________
   Name

- **Rescue and Medical Duties**

The following personnel are trained and certified in both cardiopulmonary resuscitation (CPR) and general first aid. In case of medical emergency, they are available to assist until outside emergency personnel reach the scene.

1. ___________________________  ___________________________
   Name                        Phone

2. ___________________________  ___________________________
   Name                        Phone

3. ___________________________  ___________________________
   Name                        Phone
**Shutting Down**

In order to minimize the damage or danger from a fire or other emergency, this office has determined that certain critical operations should be shut down immediately. The following personnel are responsible for shutting down the listed critical operations:

<table>
<thead>
<tr>
<th>Name of Personnel</th>
<th>Critical Operation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Notice of Medicare Non-Coverage

Patient name: <insert name>  Patient number: <ID>
The Effective Date Coverage of Your Current < insert provider type > Services Will End: <insert date>

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current < insert provider type > after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO, Telephone: 1 (888) 317-0751, TTY 1 (855) 843-4776 to appeal, or if you have questions.

See page 2 of this notice for more information.
If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: CarePlus Health Plans, Inc., 11430 NW 20th Street, Suite 300, Miami, FL 33172; Telephone: 1 (800) 794-5907 TTY: 711; Fax: 1 (800) 956-4288
From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.

Additional Information (Optional): Only to be used when the patient is incapable or incompetent and the provider cannot obtain the signature of the patient’s representative through direct personal contact.

NOTIFICATION

Select one:  □ Telephonic outreach  □ Refusal to Sign  □ Unable to Sign

- Name and relationship: ______________________________ Phone #: __________________
- Notice of Medicare non-coverage & appeal rights explained: Y / N
- Provided effective date of ______________ as date of skilled services ending: Y / N
- Provided financial liability begin date of ______________: Y / N
- Informed that a request for an immediate appeal should be made as soon as possible, but no later than noon the day before the effective date: Y / N
- QIO - KEPRO Telephone # 1-88-317-0751 given: Y / N
- Informed that if the deadline to appeal with the QIO is missed, an appeal through CarePlus Health Plans phone number 1-800-794-5907 can be requested: Y / N
- Confirmed that the representative understood all information as explained: Y / N
- Date of contact: ___________________ Time of contact: __________ a.m. / p.m.
- Name and title of the staff person initiating the contact: __________________________________
- (When applicable: ) Reason for refusal/unable to sign: __________________________________

UNABLE TO GIVE INFORMATION

- Name and relationship of the person attempted to call: ______________________________
- Phone #: __________________
- Date of first call: ______________ Time of first call: __________ a.m. / p.m.
- Date of second call: ______________ Time of second call: __________ a.m. / p.m.

*Mail a copy of letter to the contact person by certified mail with return receipt, on same day as the 2nd attempt.

Please sign below to indicate you received and understood this notice.
I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative ____________________________ Date ____________________________

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953
H1019_HSNOMNCLE2020_C
IMPORTANT!

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. CarePlus complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CarePlus, there are ways to get help.

- You may file a complaint, also known as a grievance, with:

  CarePlus Health Plans, Inc. Attention: Member Services Department.
  11430 NW 20th Street, Suite 300. Miami, FL 33172.

  If you need help filing a grievance, call 1-800-794-5907 (TTY: 711). From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day.

- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).


Auxiliary aids and services, free of charge, are available to you.

1-800-794-5907 (TTY: 711)

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.

1-800-794-5907 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 연사 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagang ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nèmew ki pi wo la a, pou resewa sevís e pò pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d’aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsleistungen zu erhalten.

ગુજરાતી (Gujarati): સન્ન સાથે સહાય સેવાઓ પરાપ્ત કરવા માટે તેથી સંપર્ક નકાશ પર કોલ કરો.

ภาษาไทย (Thai): โทรมาที่번호ด้านบนเพื่อขอรับบริการขับนักภาษาไทยแบบไม่เสียค่าใช้จ่าย.

Dîné Bizaad (Navajo): Wódahí béésh bee hani’i bee wóla’tigii bichi’íi hódiilníih éí bee táátsh binééjígíí bínáhchíí bínáhchíí bínáhchíí bínáhchíí bínáhchíí bínáhchíí bínáhchíí bínáhchíí.

العربية (Arabic):

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغة بلغتك الأصلية.