Dear Provider:

I would like to personally welcome you to Doctors HealthCare Plans, Inc. Our dedicated team of highly experienced health care professionals will work diligently to ensure a smooth experience with our Health Plan and to ultimately improve the way that local health care is delivered.

This Provider Manual has been specifically designed to assist you in meeting the requirements of administering our products and services as well as provide operational guidance to complement your Provider Agreement.

Doctors HealthCare Plans, Inc., (DHCP) is a Medicare Advantage HMO Plan with a Medicare contract operating in Miami Dade County. Enrollment in the plan depends on contract renewal. We offer a wide range of benefits and services for eligible Medicare beneficiaries, including access to a large network of primary care and specialty physicians as well as ancillary/facility providers, wellness and preventive health screenings, prescription drug coverage (Part D), and medical case management. Our aim is to maintain a comprehensive network with an array of geographically dispersed health care professionals and providers, ensuring that our Members have access to the care they need 24 hours a day, 365 days a year.

Periodic additions or changes to this Provider Manual may be required due to regulatory changes, internal policy revisions, or general updates that affect the manner in which we operate as a Medicare Advantage Plan. In these instances, we will supply the necessary documentation with clear instructions to either add to or replace the information in the Provider Manual.

You may request additional print copies of the Provider Manual from your Provider Relations Representative at no cost. The Provider Manual may also be downloaded as a PDF document directly from our website. Select “Physicians and Providers” from the menu tab on our website (www.doctorshcp.com) and click on Provider Manual.

We look forward to partnering with you and always welcome your feedback on the services we provide. On behalf of the entire team at Doctors HealthCare Plans, thank you for being an integral part of delivering quality health care services to our Members.

Sincerely,

RAFAEL PEREZ
Chief Executive Officer
Doctors HealthCare Plans, Inc.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>WELCOME LETTER</td>
<td>2</td>
</tr>
<tr>
<td>QUICK REFERENCE GUIDE: CONTACT INFORMATION</td>
<td>7</td>
</tr>
<tr>
<td><strong>01 MANUAL OVERVIEW</strong></td>
<td>8</td>
</tr>
<tr>
<td>Purpose</td>
<td></td>
</tr>
<tr>
<td>Confidentiality of Patient Information</td>
<td></td>
</tr>
<tr>
<td>Participating Physicians and Providers</td>
<td></td>
</tr>
<tr>
<td>Medicare Advantage Program Requirements</td>
<td></td>
</tr>
<tr>
<td><strong>02 ORGANIZATIONAL GOALS AND OBJECTIVES</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>03 GOVERNANCE OVERSIGHT COMMITTEE STRUCTURE</strong></td>
<td>18</td>
</tr>
<tr>
<td><strong>04 PROVIDER RELATIONS DEPARTMENT</strong></td>
<td>23</td>
</tr>
<tr>
<td><strong>05 PHYSICIAN/PROVIDER RESPONSIBILITIES (PROVIDER PROTOCOLS)</strong></td>
<td>26</td>
</tr>
<tr>
<td>Accessibility and Availability of Services</td>
<td></td>
</tr>
<tr>
<td>Environment of Care and Safety at Provider Practice Sites</td>
<td></td>
</tr>
<tr>
<td>Physician Extenders</td>
<td></td>
</tr>
<tr>
<td>Patient Care Services</td>
<td></td>
</tr>
<tr>
<td>Plan Standards</td>
<td></td>
</tr>
<tr>
<td>Expected Professional Conduct During Physical Examinations</td>
<td></td>
</tr>
<tr>
<td>Confidentiality of Specified Member Information and Medical Records</td>
<td></td>
</tr>
<tr>
<td>Release of Member Information</td>
<td></td>
</tr>
<tr>
<td>Reporting Adverse Incidents to Plan</td>
<td></td>
</tr>
<tr>
<td>Fraud, Waste &amp; Abuse</td>
<td></td>
</tr>
<tr>
<td>Covering Physicians</td>
<td></td>
</tr>
<tr>
<td>Closing a Physician Panel</td>
<td></td>
</tr>
<tr>
<td>Provider Billing and Address Changes</td>
<td></td>
</tr>
</tbody>
</table>
Encounters and Other Data
Advance Directives
Provider Appeals Process
Privacy and Confidentiality of Member Medical Records
Other Regulatory Requirements, Plan Policies and Standards
Hold Harmless
Provider Marketing

06 PHYSICIAN/PROVIDER CREDENTIALING . . . . . . . . . . . . . . . 47
  Initial Credentialing
  Re-Credentialing
  Site Review Visit
  Plan Credentialing Committee
  Provider Termination
  Provider Termination Appeal Process

07 CLAIMS . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 53
  General Claims Information
  Provider Identification (ID) Number Requirements
  Electronic Claims Submission
  Paper Claims Submission
  Coding
  Claims Filing Deadlines
  Claims Disputes

08 QUALITY IMPROVEMENT . . . . . . . . . . . . . . . . . . . . . . . . . . . . 62
  Scope
  Medical Records Recording and Maintenance Criteria
  Access Standards
  Member Health Education and Wellness Promotion
Preventive Health Services
Targeted Disease Management Programs
Quality Improvement Initiatives, Studies and Projects
Member Satisfaction
Provider Satisfaction
Peer Review Process

**MEDICAL MANAGEMENT/CASE MANAGEMENT** . . . . . . 72
Utilization Management Decision Making
Medical Management (MM) Process
Notifications
Prior Authorizations
Services Not Requiring Authorization By Plan
Concurrent Review
Discharge Planning
Retrospective Review: For Hospital Admissions
Standards, Expedited and Extensions of an Organization Determination
Standard Organization Determination (Approval or Denial)
Expedited Organization Determination
Medicare QIO Review Process for Inpatient and SNF/HHA/CORF Terminations
Emergency Services
Second Medical Opinion
Out of Network
Care Transition/Coordination of Care
Transplant Management
Case Management
**Quick Reference Guide: Contact Information**

| Corporate Address | Doctors HealthCare Plans, Inc.  
| | 2020 Ponce de Leon Blvd., PH 1  
| | Coral Gables, FL 33134 |
| Corporate Office Business Hours | 8AM to 6PM ET |
| Main Corporate Phone Number | (786) 578-0965 |
| Provider Relations | (305) 422-9300 |
| Medical Management | Prompt 1 |
| Medical Management Fax | (786) 578-0291 |
| Provider Relations Department & Claims Status | Prompt 2 |
| Member Eligibility & Services | Prompt 3 |
| Pharmacy | Prompt 4 |
| Pharmacy Fax | (866) 291-3725 |
| Member Services | (786) 460-3427 |
| Member Services toll free | (833) 460-3427 |
| Case Management | (786) 785-3427 |
| TTY | 711 |
| Marketing & Sales | (786) 420-3427 |
| | (833) 639-3427 |
| Fraud, Waste & Abuse Hot Line | (833) DHCP911; (833) 342-7911 |
| Compliance | (833) 500-3427 |

Report issues to FWA email reportfraud@doctorshcp.com or call (833) 342-7911. This line is confidential and available 24 hours a day, 7 days a week. Report issues to Compliance email (compliance@doctorshcp.com) or Compliance Help Line (833) 500-3427. The Help Line is confidential, toll-free resource available 24 hours a day, 7 days a week to report violations or raise questions or concerns related to compliance. Calls may be made anonymously.

| Transportation Services | (786) 789-3427 |
| Web site address | www.doctorshcp.com |

NOTE: Members may arrange for non-emergency medical transportation directly by calling (786) 789-3427 with 72 hours prior notice of the medical appointment to and from approved provider locations.

**Electronic Claims Submission (EDI)/Exchange**

| Paper Claims Submission Only: Your addressee posting and intended recipient must be listed as indicated: |
| Doctors HealthCare Plans, Inc. |
| Claims Department |
| P.O. Box 132 |
| 1825 Ponce de Leon Blvd. |
| Coral Gables, FL 33134 |

**Provider Claims Disputes:** Participating Providers must submit their claims disputes within 120 calendar days from the date of the corresponding Remittance Advice to the following address:

| Doctors HealthCare Plans, Inc. |
| Provider Inquiry Unit |
| 2020 Ponce de Leon Blvd., PH 1 |
| Coral Gables, FL 33134 |
I. PURPOSE

The Doctors HealthCare Plans, Inc. Provider Manual presumes that the participating provider has a general command of relevant Medicare Advantage Health Plan regulation and program policy guidance such as that contained in Title 42 Part 422 of the Code of Federal Regulations; Medicare Managed Care Manual and other applicable program memoranda and transmittals. The Provider Manual serves as an extension of the provider’s contractual Agreement with the Plan. It provides participating providers and their respective staff with the policies and procedures that guide their participation with the Plan. A copy of this manual should be maintained in the providers’ offices for reference.

Situations may arise in which professional judgment may necessitate action which differs from the guidelines in this document. In such situations, an explanation of the special circumstances which justify variation from these guidelines
should be documented and retained in the medical records or office files. If such a situation should arise where a deviation occurs, please contact our Provider Relations Department for guidance.

In the event of any inconsistency between information contained in this manual and the contractual Agreement between you and the Plan, the terms of the contractual Agreement shall govern. Additionally, inconsistency between information contained in this manual and the provision of any state or federal statute or regulation applicable to either the Plan or a contracted provider, the provisions of the statute or regulation shall have full force and effect.

This Provider Manual will incorporate any changes to Doctors HealthCare Plans, Inc’s. administrative policies and procedures that impact providers and it will be updated accordingly. Providers will be notified as needed from time to time.

A copy of this Provider Manual may be viewed or downloaded directly from our website, www.doctorshcp.com or requested by calling or e-mailing the Department of Provider Relations directly. Questions regarding the material content of this Manual or the administration of policies/procedures/processes contained herein should be addressed to the Provider Relations Department directly.

II. CONFIDENTIALITY OF PATIENT INFORMATION

Confidentiality is the responsibility of every staff member and contracted provider. The Plan is a “Covered Entity” under HIPAA (the Health Insurance Portability Affordability and Accountability Act of 1996). As a participating provider, you are our Business Associate for the purposes of HIPAA. In addition, any provider who conducts any health care transactions electronically is also a Covered Entity. As such, you are also required to comply with the HIPAA Privacy and Security Rules, as amended (the HIPAA Security Rule applies to all ePHI (electronic Protected Health Information). The American Recovery and Reinvestment Act of 2009 (ARRA) has raised the standards for Business Associates and increased penalties for data security breaches.

In addition, providers must comply with state and federal laws and regulations regarding the confidentiality of patient information, e.g., legislation pertaining to disclosure of mental health/HIV information, data breach notification, etc.

III. PARTICIPATING PHYSICIANS AND PROVIDERS

Participating physician is defined as a medical doctor or an osteopathic physician duly licensed under Chapter 458 or 459, Florida Statutes, to practice medicine or osteopathic medicine, respectively, in the State of Florida.

Participating providers are defined as a Medical Service Provider, a Participating Hospital, Nursing Home or Home Health Agency, a Participating Licensed Health Professional, a Physician, or a Primary Care Physician, as the case may be, which or who has entered into an agreement with, or is otherwise engaged by, Plan to provide Covered Medical Services to Members.

Participating Physicians and Providers include but are not limited to physicians (Doctors of Medicine or MDs; Doctor of Osteopathic Medicine or DOs), ambulatory surgery centers, diagnostic facilities, hospitals, skilled nursing facilities, pharmacies, and other health care providers such as medical laboratories and home health care agencies.

Primary Care Physicians (PCPs) are licensed, practicing physicians, or a practice group of Primary Care Physicians, or an entity employing or otherwise contracting with one or more Primary Care Physicians, and Provider is licensed
or otherwise qualified and contracted to provide Health Care Services to Members who have been assigned to Provider by Plan. A PCP is usually one of these disciplines:

- Family Physician & General Practitioner – A physician who specializes in the care of all family members regardless of age.
- Internist – A physician who specializes in internal medicine and delivers non-surgical treatment of medical conditions.

The PCP is an integral medical provider within an integrated and coordinated health care system who makes diagnoses, provides treatment, performs physical examinations, gives advice on the individual’s health and, when necessary, makes referrals to consultants and/or specialists. The PCP is considered our member’s home for medical record information.

IV. MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The Centers for Medicare and Medicaid Services (“CMS”) requires Doctors HealthCare Plans, Inc’s participating providers, vendors (“first tier entities”), their employees, contracted individuals and entities to comply with all CMS Medicare Advantage (“MA”) program requirements. Doctors HealthCare Plans, Inc’s. agreements with its first-tier entities must contain certain specific provisions. In addition, first tier entities’ agreements with their downstream entities must also contain these provisions. Therefore, please make sure that if you subcontract with a downstream entity, you make the Plan aware of such arrangement and ensure that the following provisions are included in your agreements.

These provisions are:

1. Compliance with Law. Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and applicable requirements of the contract between Plan, Inc. and CMS (the “Medicare Contract”) and with all other applicable state and federal laws and regulations, as may be amended from time to time, including, without limitation: (1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of 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); and (2) the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) administrative simplification rules at 45 CFR parts 160, 162, and 164. [42 C.F.R. § 422.504(i)(4)(v) and § 422.504(h)(1)].

2. Medicare Advantage Member Privacy and Confidentiality. Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or requirements in the Medicare Contract regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (1) HIPAA and the rules and regulations promulgated thereunder, (2) 42 C.F.R. § 422.504(a)(13), and (3) 42 C.F.R. § 422.118; (iv) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable State and/or Federal law or pursuant to valid court orders or subpoenas.

3. Audits; Access to and Maintenance of Records. Provider shall permit inspection, evaluation and audit directly by Doctors HealthCare Plans, Inc., the Department of Health and Human Services (DHHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or
their designees, and as the Secretary of the DHHS may deem necessary to enforce the Medicare Contract, of Provider’s physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to the Agreement), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, “Books and Records”). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency’s designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Medicare Advantage Members to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Plan and/or CMS with timely access to records, information and data necessary for: (1) Plan(s) to meets its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by the Health Plan(s) under the Medicare Contract. [42 C.F.R. § 422.504(e)(4), (h), (i)(2), and (i)(4)(v).]

4. **Prompt Payment of Claims.** Doctors HealthCare Plans, Inc. agrees to promptly process and pay or deny claims for Covered Services in accordance with the Provider Agreement in effect at the time of service by and between the Plan and the contracted Provider subject to 42 C.F.R. § 422.520(b). Doctors HealthCare Plans, Inc. will comply with the provisions of 42 C.F.R. § 422.520(a)(1)(2)(3) as it applies to the prompt payment of claims that are submitted by providers for services and supplies rendered to enrollees when these services and supplies are furnished by non-contracted providers. Reimbursement to non-contracted providers for covered services rendered to Health Plan members will be no greater than the amount provider would have received under original Medicare for the covered services.

5. **Hold Harmless of Medicare Advantage Members.** Provider agrees: (i) that in no event, including but not limited to, non-payment by the Plan, the Plan’s determination that services were not Medically Necessary, Plan’s insolvency, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare Advantage Member for amounts that are the legal obligation of Plan, Inc.; and (ii) that Medicare Advantage Members shall be held harmless from and shall not be liable for payment of any such amounts. Provider further agrees that this provision (a) shall be construed for the benefit of Medicare Advantage Members; (b) shall survive the termination of this Agreement regardless of the cause giving rise to termination, and (b) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medicare Advantage Members, or persons acting on behalf of an MA Member. This does not apply to the collection of co-pays/coinsurance from the Plan’s Medicare Advantage Members. [42 C.F.R. § 422.505(g)(1)(i) and (i)(3)(i).]
6. **Accountability.** Provider agrees that Doctors HealthCare Plans, Inc. shall monitor the provision of services by Provider on an ongoing basis and the Plan shall be accountable under the Medicare Contract for services provided to Medicare Advantage Members under the Agreement regardless of the provisions of the Agreement or any delegation of administrative activities or functions to Provider under the Agreement. [42 C.F.R. § 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii).]

7. **Delegated Activities.** Provider acknowledges and agrees that to the extent Doctors HealthCare Plans, Inc., in its sole discretion, elects to delegate any administrative activities or functions to Provider. Provider understands and agrees that: (i) Provider may not delegate, transfer or assign any of Provider’s obligations under the Agreement and/or any separate delegation agreement without Plan’s prior written consent; and (ii) Provider must demonstrate, to Plan’s satisfaction, Provider’s ability to perform the activities to be delegated and the parties will set out in writing: (1) the specific activities or functions to be delegated and performed by Provider; (2) any reporting responsibilities and obligations pursuant to Doctors HealthCare Plans, Inc.’s policies and procedures and/or the requirements of the Medicare Contract; (3) monitoring and oversight activities by the Plan, including without limitation review and approval by Plan of Provider’s credentialing process, as applicable, and audit of such process on an ongoing basis; and (4) corrective action measures, up to and including termination or revocation of the delegated activities or functions and reporting responsibilities if CMS or Plan determines that such activities have not been performed satisfactorily. [42 C.F.R. § 422.504(i)(3)(iii); 422.504(i)(4)(i)-(v).]

8. **Compliance with Plan Policies and Procedures.** Provider shall comply with all policies and procedures of Doctors HealthCare Plans, Inc. including, without limitation, written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (c) provider consideration of Medicare Advantage Member input into Provider’s proposed treatment plan; and (d) Doctors HealthCare Plans, Inc., compliance program which encourages effective communication and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. [42 C.F.R. § 422.112; 422.504(i)(3)(iii); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

9. **Continuation of Benefits.** Provider agrees that except in instances of immediate termination by the Plan for reasons related to professional competency or conduct and upon expiration or termination of the Agreement, Provider will continue to provide Covered Services to Medicare Advantage Members as indicated below and to cooperate with the Plan to transition Medicare Advantage Members to other Participating Providers in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of the Medicare Contract, the Plan’s accrediting bodies and applicable law and regulation, Provider will continue to provide Covered Services to Medicare Advantage Members after the expiration or termination of the Agreement, whether by virtue of insolvency or cessation of operations of the Plan, or otherwise: (i) for those Medicare Advantage Members who are confined in an inpatient facility on the date of termination until discharge; (ii) for all Medicare Advantage Members through the date of the applicable Medicare Contract for which payments have been made by CMS to the Plan; and (iii) for those Medicare Advantage Members undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (ii) above. [42 C.F.R. 422.504(g)(2) & (3).]

10. **Physician Incentive Plans.** The parties agree: (i) that nothing contained in the Agreement nor any payment made by Doctors HealthCare Plans, Inc. to Provider is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Medicare Advantage Members; and (ii) that any incentive plans
between Plan and Provider and/or between Provider and its employed or contracted physicians and other health care practitioners and/or providers shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Medicare Contract. Upon request, Provider agrees to disclose to the Plan the terms and conditions of any “physician incentive plan” as defined by CMS and/or any state or federal law, rule or regulation. [42 C.F.R. § 422.208].

11. Disclosure Requirements. The parties agree to comply with the contract provisions in 42 CFR 504 and 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. This information includes, but is not limited to:

- The benefits covered under the Health plan;
- The monthly basic beneficiary premium and monthly supplemental beneficiary premium, if any, for the Plan.
- The service area of each health plan and the enrollment capacity of each health plan;
- Quality and performance indicators for the benefits under the Plan including:
  1. Disenrollment rates for Medicare enrollees electing to receive benefits through the Plan for the previous 2 years;
  2. Information on Medicare enrollee satisfaction;
  3. Information on health outcomes;
  4. The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and
  5. Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;
- Information about beneficiary appeals and their disposition;
- Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;
- To CMS, any other information deemed necessary by CMS for the administration or evaluation of the Medicare program;
- To its Plan’s enrollees all informational requirements under §422.64 and, upon an enrollee’s, request the financial disclosure information required under §422.516.
Doctors HealthCare Plans, Inc. is a licensed and certified health maintenance organization (HMO) in accordance with Chapter 641 of the Florida Statute with the Office of Insurance Regulation in the State of Florida’s Department of Financial Services. The Plan holds a contract with the Centers for Medicare and Medicaid Services (CMS) in order to offer Medicare Advantage plans.
Doctors HealthCare Plans, Inc. is pleased that you have agreed to participate in the Plan. We look forward to working with you to provide Plan members with quality health care and an exceptional level of service. In this section, we highlight some of the goals and objectives that guide the Plan in the provision of health care and service to members.

Our Goals include:

- Design benefits and services to improve and maintain members’ physical and emotional wellness
- Empower members to maintain healthy lifestyles
- Involve members in their treatment and care management decision-making process
- Ensure covered benefits and services are based on evidenced-based guidelines, standards, and community practices
- Be accountable and responsive to our member’s rights, concerns and grievances
- Use technology and other resources efficiently and effectively
- Monitor availability and accessibility of covered services through a comprehensive network of credentialed and contracted providers

Our Objectives:

- Maximize the efficiencies of the Plan’s participating provider network to enable the provision of quality health care services in the most cost effective and appropriate patient care settings
- Employ methods of best practice using evidence-based guidelines to improve care and service to members
- Evaluate new technology to improve quality of care and service to members
- Provide mechanisms to monitor the consistency and continuity of care throughout the Plan’s participating network
- Ensure systematic identification and remedial follow-up of potential or actual quality of care/quality of service issues and implement corrections to prevent recurrence
- Educate members and providers about the Plan’s goals, objectives and structure for providing quality, cost effective, and coordinated managed clinical and behavioral health care
- Promote open communication and interaction between providers and members
- Conduct population assessments to identify cultural and linguistic specific norms
- Measure effectiveness of covered services provided through nationally accepted standards such as HEDIS and STARs

Physician Consultation in Medical Policies:

Doctors HealthCare Plans, Inc. may consult with participating physicians to ensure proper compliance with policies, including medical management, care/case management, discharge planning, health assessments, quality assurance, quality improvement programs. These efforts include:

- Practice guidelines and utilization management guidelines which are approved based on nationally accepted guidelines, clinical evidence and/or by consensus of health care professionals in the particular field and in the community;
- Consider the cultural and linguistic needs of the enrolled population;
- Be developed in consultation with participating providers, including behavioral health;
• Be reviewed and updated periodically;
• Be communicated to providers, and, as appropriate, to enrollees;
• Decisions with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply.

**Written Information on Physician/Provider Participation:**

We must provide you with written information on physician/provider participation regarding:

• Rules of participation including terms of payment, credentialing, and other rules directly related to participation decisions;
• Material changes in participation rules before the changes are put into effect; and
• Adverse participation decisions
• The process for requesting standard and expedited organizational and coverage determinations

**Interference with Health Care Professionals’ Advice to Enrollees Prohibited:**

Doctors HealthCare Plans, Inc. will not prohibit or otherwise restrict you from advising, or advocating on behalf of an enrollee of the Plan about:

• The patient’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options;
• The risks, benefits, and consequences of treatment or non-treatment; or
• The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

As a general rule, Doctors HealthCare Plans’ prohibition or restriction from interfering with a providers’ advice to enrollees does not require the Plan to cover, furnish, or pay for a particular service.

**Provider Anti-Discrimination:**

Doctors HealthCare Plans, Inc. may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license or certification, solely on the basis of the license or certification.

However, this prohibition does not preclude the Plan from any of the following actions:

• Refusal to grant participation to physician/providers applicants in excess of the number necessary to meet the needs of the plan’s enrollees.
• Use of different reimbursement amounts for different specialties or for different participating providers in the same specialty.
• Implementation of measures designed to maintain quality and control costs consistent with its contractual responsibilities.
What does this mean to Participating Providers?

As a Plan Participating Provider, we need your full cooperation in complying with Medicare regulations, sub-regulatory guidance, the Doctors HealthCare Plan’s contractual agreement(s) with you, and all applicable Federal and State laws, as well as Plan policies and procedures that protect against Medicare program noncompliance and potential Fraud/Waste/Abuse. The Provider Relations team will educate participating providers on operational processes and procedures pursuant to the terms and conditions of the Participating Provider Agreement and this Provider Manual. Thereafter, Provider Relations will serve to provide you with the on-going operational and technical support required to ensure our successful partnership.

In order to monitor compliance with administrative policies and procedures, the Plan will perform various levels of regular reviews including provider site visits by designated Provider Relations Representatives as part of normal operations to confirm ongoing compliance. If applicable, a formal review or audit of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) may be used as base measures for compliance.
Doctors HealthCare Plan’s committees are structured to promote company-wide participation and involvement of the Plan’s network providers in the development, implementation, and evaluation of quality management and other administrative activities to improve the overall health care delivery of our members.
BOARD OF DIRECTORS (BOD)
The Board of Directors of Doctors HealthCare Plans, Inc. is responsible for and holds the final authority for all operations of the health plan. The BOD sets policy, is responsible for the organization, and is administered in a manner that ensures the provision of high-quality health care services. Company financial statements and financial audit reports are reviewed and timely submission is verified. The board also ensures compliance with federal and state anti-discrimination laws. The BOD fulfills the organization’s mission, goals, and objectives.

An accreditable organization has a governing body that sets policy, is responsible for the organization, and is administered in a manner that ensures the provision of high-quality health care services, and that fulfills the organization’s mission, goals, and objectives. The BOD maintains meeting minutes and records to demonstrate focus on providing quality health care to members.

QUALITY IMPROVEMENT COMMITTEE (QIC)
The QIC is responsible for oversight of the company’s Quality Improvement Program including management representing various departments, including Member Services, Network Development, Operations, Quality and Risk Management, etc. Compliance Committee will share Policies and Procedures and other information to QIC, however reports directly to the Board of Directors.

Responsibilities of the QIC include:

• Providing direction and oversight for the development, monitoring, evaluation and enhancement of the company’s Quality Improvement Program;
• Establishing and monitoring key performance indicators;
• Establishing and monitoring organizational performance goals for clinical care consistent with HEDIS criteria and national Medicare benchmarks;
• Facilitating and monitoring performance improvement activities;
• Reviewing reports from committees reporting to the QIC;
• Oversight of delegated entities and approval of delegation decisions;
• Evaluating the effectiveness of the Quality Improvement Program at least annually;
• Review results of member and provider satisfaction surveys;
• Ensure policies and procedures are current with regulations/contracts for complaints, grievances, appeals, and requests for reconsideration.

RISK MANAGEMENT COMMITTEE
The Risk Management Committee is responsible for the oversight of the comprehensive Risk Management program which protects the safety of all Employees, Members, Providers, and Visitors. The goal of the committee is to minimize the risk of injuries and incidents and maximize the quality of care. The committee will analyze all events to determine frequency, significance, and impact on members and the health plan.

CREDENTIALING COMMITTEE
The Credentialing Committee is chaired by the Chief Medical Officer or designee and includes network primary and specialty care providers. The Credentialing Committee is responsible for the overall direction of the credentialing program. Responsibilities include:

• Providing input on Plan credentialing program and standards;
• Evaluating applicants, verifying qualifications and credentials in accordance with regulatory requirements, accreditation standards, and plan policy;
• Evaluating applicants’ professional license status, history of medical board disciplinary actions, malpractice claims history/cases, complaints filed by Plan members and any other factors included in Plan’s credentialing standards;
• Ensuring appropriate clinical peer input when discussing standards of care for a particular type of provider;
• Approving or disapproving initial and re-credentialing applications for network participation.
• Maintaining strict confidentiality practices regarding all information obtained through the credentialing process.
• Ensuring adequate processes are in place to suspend or terminate providers in the network and allow for appeal provisions.

Voting members include credentialed providers. Decisions, determinations, and recommendations are presented to the QIC for review/approval. The Credential Committee holds the authority for approval/denial of applicant providers, however, final ratification remains with the Board of Directors. Minutes sent to the QIC and BOD are considered evidence of their ratification.

APPEALS AND GRIEVANCE COMMITTEE
The Appeals and Grievance Committee analyzes member appeals and grievances and notes any trends. The committee will make recommendations to the various operational areas for process improvement as well as forward any quality concerns to the QIC. It meets on an ad-hoc basis with the majority of activities taking place at the QIC.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE
The P&T Committee’s goal is to promote safe, cost-effective, and quality drug therapy that appropriately reflects community and national standards of practice. The P&T Committee approves the Formulary and promotes clinically appropriate, safe, and cost-effective drug therapy. Committee members meet regulatory on accreditation requirements and include practicing physicians and pharmacists with diverse clinical expertise; the majority are active in clinical practice.
The P&T Committee:

- Reviews for clinical appropriateness the practices and policies for formulary management activities, such as prior authorizations, step therapies, quantity limitations, generic substitutions, and other drug utilization activities that affect access.
- Bases formulary management decisions on scientific evidence, and pharmacoeconomic considerations that achieve appropriate, safe, and cost-effective drug therapy.
- Establishes and documents procedures to ensure appropriate drug review and inclusion. This includes documentation of decisions regarding formulary development and revision, and utilization management activities.
- Bases clinical decisions on scientific evidence and standards of practice and utilizes approved Compendia as reference.
- Considers drugs’ therapeutic advantages in terms of safety and efficacy when selecting formulary drugs and placing them on formulary tiers.

PEER REVIEW COMMITTEE

The Peer Review Committee is a sub-committee of the QIC and is responsible for reviewing cases involving the professional competence or conduct of providers which could potentially adversely affect member welfare. It is chaired by the Chief Medical Officer or designee and includes representation by Risk Management, Quality Management, and network providers. In addition to standing members, network providers are invited on an ad hoc basis in order to provide appropriate peer/specialty representation for the case or issue under review. Minutes and activities of the Peer Review Committee are confidential and not allowed to be further disclosed. Responsibilities of the Peer Review Committee include:

- Evaluation of cases, events or situations with actual or potential impact on quality of care;
- Conducting objective evaluations and making decisions using evidence-based medicine and established standards of care;
- Evaluating committee membership for appropriate health care specialty representation for the case or issue under review;
- Participation in the peer review appeal process;
- Providing input on the re-credentialing process;
- Maintaining strict confidentiality practices regarding all information obtained through the peer review process.

MEDICAL MANAGEMENT COMMITTEE (MMC)

The MMC is chaired by the Medical Director and includes representation by Health Services, Quality Improvement and network providers. The MMC is responsible for the oversight of clinical quality activities, including:

- Development and monitoring of clinical quality activities and practice guidelines is done in consultation with contracting physicians.
- Ensuring that the needs of the enrollees are considered and met in the development of clinical quality activities, clinical protocols and guidelines, and scripts.
- Research, periodic updates and reviews and approval of established clinical protocols and guidelines and scripts based on evidence-based medicine;
- Monitor utilization of health services; identify and respond to trends, including coordination of care and under and over-utilization;
- Evaluation and approval of chronic care programs, including disease and case management;
- Providing recommendations, evaluating and making decisions regarding interventions targeting member health status.
COMPLIANCE COMMITTEE
The Compliance Committee is chaired by the Compliance Officer and is composed of business leaders from each area. The committee is responsible for the implementation, operation, and oversight of the Compliance Program and has full decision-making authority for the Organization as it relates to compliance. The Compliance Committee is responsible to ensure sufficient funding and support for DHCP Compliance Program. The Compliance Committee is accountable to DHCP Board of Directors. The Compliance Officer meets with the DHCP Board of Directors as needed. The Board of Directors remains responsible for being knowledgeable about the content and operation of the Compliance Program and must exercise reasonable oversight with respect to the implementation and effectiveness of the Compliance Program. The Compliance Committee shall be responsible for the following:

- Developing strategies to promote compliance and the detection of any potential violations;
- Reviewing and approving compliance and FWA training, and ensuring that training and education are effective and appropriately completed;
- Assisting with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work plan;
- Assisting in the creation, implementation and monitoring of effective corrective actions;
- Developing innovative ways to implement appropriate corrective and preventative action;
- Reviewing effectiveness of the system of internal controls designed to ensure compliance with Medicare regulations in daily operations;
- Supporting the compliance officer’s needs for sufficient staff and resources to carry out his/her duties;
- Ensuring the sponsor has appropriate, up-to-date compliance policies and procedures;
- Ensuring the sponsor has a system for employees and FDRs to ask compliance questions and report potential instances of Medicare program noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation;
- Ensuring the sponsor has a method for enrollees to report potential FWA;
- Reviewing and addressing reports of monitoring and auditing of areas in which the sponsor is at risk for program noncompliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness;
- Providing regular and ad hoc reports on the status of compliance with recommendations to the sponsor’s governing body.

Network providers are invited and encouraged to serve on the Credentialing Committee or the Medical Management Committee and its Peer Review sub-committee. If you are interested in learning more about these opportunities please contact the Network Development Department or the Medical Director for information. We welcome your inquiry.
Doctors HealthCare Plans, Inc. has established the Department of Provider Relations within its corporate structure. The Department employs personnel dedicated to supporting our participating providers with the operational policies and procedural requirements of the Plan. As such, the Provider Relations Department is responsible for providing professional and technical assistance to the Plan’s participating providers commencing on the effective date of the provider’s contract with the Plan.

In this supporting role, the Provider Relations Department will attempt to conduct an initial comprehensive training session within ten (10) business days following the effective date of the participating provider’s contract with the Plan.
At a minimum, the initial training session is comprised of the review and discussion of this Provider Manual to include the following:

a) Member Eligibility & Benefit Questions,
b) Clinical record policies and procedure
   – Member information
   – Storage and maintenance of records
   – Confidentiality of records
   – Retrieval of records
   – Release of records
c) Encounter Submission & Provider Data Reporting,
d) Claim Submission Protocols/Inquiries,
e) Organization Determinations (Part C)
f) Coverage Determinations (Part D)
g) Dispute & Appeals Process including,
   – Reconsiderations and Redeterminations (Level 1 Appeals)
   – Reconsiderations by Independent Review Entity (Level 2 Appeal)
   – Third Level Appeals consisting of a hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals.
h) Management
i) Pre-Authorization Policies and Processes applicable for levels of care as follows:
   – Urgent care pre-service
   – Non-urgent care pre-service
   – Concurrent care
   – Post-service care
j) Fraud and Abuse,
k) Compliance and FWA Training (Plan or Provider), Code of Conduct, HIPPA. (Must be completed within 90 days of contracting and annually thereafter).
l) Provider Portal, Functionalities, and Registration
m) Provider Performance Report Card, and
n) General Policies and Procedures

A copy of the Notice of Educational In-Service Acknowledgement will be presented to the office manager or participating provider for signature upon completion of the initial orientation. A copy of the Acknowledgement will be maintained on file attesting to the participating provider having received the Provider Manual and initial comprehensive training of applicable policies and procedures.

The Department of Provider Relations has established a policy of conducting provider onsite visits to your office on a recurring schedule. Periodic visits will be conducted for purposes of assessing your site location(s) on a precontractual basis as part of the credentialing and recredentialing process. Credentialing and recredentialing site visits evaluate the site’s accessibility, appearance, and adequacy of equipment using standards adopted by the
Plan. In addition, these type visits include a determination of whether the site conforms to Doctors HealthCare Plans’ standards for medical record keeping practices and the confidentiality requirements.

Periodic site visits will also be conducted for primary care physicians and high-volume providers geared towards monitoring the overall operational performance of the provider network and identifying inefficiencies that may require remedial intervention.

Doctors HealthCare Plans, Inc. may also consider developing criteria that target other providers, or those for whom patterns of noncompliance have been identified and grievances have been filed.

A copy of the of the completed site visit tool requires the signature of the office manager or participating physician/provider. Copies of all completed site visit tools will be maintained on file as indication of the participating physician’s/provider’s collaboration in assessing compliance with the following:

- Primary Care Physicians are credentialed and contracted by DHCP
- Covering Physicians are identified for the purpose of ensuring primary care physicians have appropriate backup for absences.
- Hours of Operations are adequate at practice site; services are available 24 hours a day, 7 days a week and common waiting times for comparable services in the community are observed as follows:
  - (1) urgently needed services or emergency - immediately;
  - (2) services that are not emergency or urgently needed, but in need of medical attention - within one week; and
  - (3) routine and preventive care - within 30
- Access to behavioral health and substance abuse treatment and services are available 24 hours a day, 7 days a week and service standards are observed as follows:
  - (1) Routine Care, within 10 days
  - (2) Urgent Care, within 48 hours
  - (3) (Non-threatening emergency care, within 6 hours
  - (4) Life-threatening emergency care, within 24 hours/7 days a week
- Ensure that all clinical and non-clinical services are provided in a culturally competent manner and are accessible to Plan members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds through the provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.
- The practice’s billing policy implements methodology which allows for timely, accurate encounter and/or claims electronic or manual submission.
I. ACCESSIBILITY AND AVAILABILITY OF SERVICES

Physicians/Providers are expected to:

a) Be available to provide or arrange for provision of medical services to Members 24 hours a day, 7 days a week.
b) Arrange for, and compensate financially for, on-call and after-hours coverage as well as coverage for other absences (illness, holidays, vacation) by utilizing participating and credentialed Plan Physician/Providers of similar specialty.

c) Comply with Plan standards for timely access to care and services to as follows:
   1. Urgent Care – within 24 hours
   2. Routine Care – within one week
   3. Well Care – within one month
   4. In-office wait time should not exceed thirty minutes (30) from the time of check-in to time at which the Physician/Provider sees the patient.

d) Ensure accessibility of services to members by maintaining a ratio of patients to full-time equivalent (FTE) physicians as follows:
   • One (1) physician FTE to 2500 Medicare members.
   • An allied health care professional (PA or ARNP) counts as 0.5 physician FTE for Medicare.

e) Will have hours of operation that do not discriminate against particular needs of Plan members.

Not discriminate on the basis of any factor that is related to health status, including, but not limited to the following:
(1) Medical condition, including mental as well as physical illness. (2) Claims experience. (3) Receipt of health care.
(4) Medical history. (5) Genetic information. (6) Evidence of insurability, including conditions arising out of acts of domestic violence. (7) Disability.

II. ENVIRONMENT OF CARE AND SAFETY AT PROVIDER PRACTICE SITES

The benefits and services provided by the Health Plan’s contracted provider network must adhere to safety and infection control practices for the Plans’ members. Doctors HealthCare Plans will ensure the Provider Network has established programs which are designed to (a) prevent infections and health hazards (b) provide care under conditions which are safe and sanitary as evidenced by the following practice protocols:

1. Have fully implemented infection prevention programs in their practice sites which conform to nationally recognized standards, such as those of the Centers for Disease Control (CDC).

2. Implement infection control guidelines that ensures office staff is educated on infection control processes such as proper hand hygiene and safe injection practices.

3. Practice sites have a safety program in place that:
   a. Manages would – be threats and health hazards
   b. Monitors products, medications with expiration dates
   c. Avoids medication errors
   d. Prevents falls and potential physical injuries

4. Have a process to report adverse incidents which may impact the organization as well as report onward to state and federal agencies if applicable.

5. Have safety plans for emergencies, evacuations, and disaster preparedness which comply with federal, state and local safety and fire prevention regulations.
III. PHYSICIAN EXTENDERS

Participating physicians may utilize the services of participating physician extenders. A physician extender is a health care provider who is not a physician but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant (PA), Advanced Registered Nurse Practitioners (ARNPs), and individuals other than physicians who may provide direct patient care within the scope of practice established by the rules and regulations of the State of Florida and Plan guidelines. Physician Extenders must be credentialed and contracted by the Plan before rendering services to the Plan’s enrollees.

- Sponsoring physicians will assume full responsibility to the extent of the law when supervising physician extenders. Sponsoring physicians are also responsible for implementation of written policies (as required) to enforce statutory requirements for licensure, delegation, collaboration, and supervision of these staff.
- Physician Extenders should clearly identify themselves to patients, as well to other health care professionals.
- Any patient request to be seen by a physician, rather than a physician extender, must be honored at all times.

IV. PATIENT CARE SERVICES

Physicians are expected to adhere to the following patient care services guidelines:

- Provide comprehensive health services and care to Plan members and refer Plan members with problems outside their scope of practice for consultation and/or care to appropriate Plan contracted specialists on a timely basis.
- Refer members only to network Physicians/Providers, except when they are not available, or in an emergency.
- Submit referral information to Plan in a timely manner.
- Admit members only to participating Plan network hospital, SNFs, and other inpatient care facilities, except in an emergency.
- Adhere to Plan clinical practice guidelines as made available to participating providers.
- Obtain prior authorizations as required by Plan and provide appropriate information to the Plan member.
- Not to discriminate based on a member’s health status, race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or genetic information.
- Not to discriminate in any manner a Plan member from any other patients.
- Counsel members on follow-up care and provide training in self-care as necessary.
- Work cooperatively with other practitioners and uphold the standard of ethics for the health care profession.
- Provide or coordinate health care services that meet generally recognized professional standards and those standards provided by Plan in the areas of operations, clinical practice guidelines, customer satisfaction, and fiscal responsibility.
- Discuss all aspects of a member’s health with him/her, and be cognizant of the member’s health benefits to ensure that conversations about treatment options are comprehensive.
- Understand that the information provided in the Physician/Provider contractual agreement or the Provider Manual is not intended to interfere with or hinder communications between Providers and Members regarding a patient’s medical condition or available treatment options.
• Maintain an environmentally safe office with equipment in proper working order and up to date certifications and/or licenses publicly displayed on site to comply with City, State, and Federal regulations concerning safety and public hygiene.
• Transfer copies of medical records to other Plan Physicians/Providers upon request and at no charge to Plan, the member, or the requesting party, unless otherwise agreed upon.
• Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen.
• Fully disclose treatment to members.
• Provide services in a culturally competent manner, i.e., remove all language barriers to those patients with limited English proficiency or reading skills, as well as those with diverse cultural and ethnic backgrounds.
• Meet the requirements of all applicable State and Federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and the Health Insurance Portability and Accountability Act (HIPAA).
• Adhere to HIPAA guidelines and requirements.

V. PLAN STANDARDS

• Provide quality, cost effective health care without compromising patient care.
• Abide by the rules and regulations and all other lawful standards and policies of Plan.
• The PCP agrees to accept Plan members as required by the Primary Care Provider Agreement.
• The PCP must not refuse new members until such time he/she can reasonably demonstrate to Plan that his/her panel size has reached the maximum for adding new members, or upon mutual agreement with Plan. A sixty (60) day notice is required to close panels.

VI. EXPECTED PROFESSIONAL CONDUCT DURING PHYSICAL EXAMINATIONS

Physicians are expected to adhere to the following guidelines for physical examinations of Plan members:
• The Physician/Provider should obtain agreement from the member prior to performing a genital examination, rectal examination, or female breast examination.
• To decrease the risk of allegations of misconduct, Physicians/Providers examining the opposite sex should routinely have a chaperone in the room during female breast or pelvic or a male hernia or prostrate examinations. The chaperone should:
  Remain in the room for as long as the patient is being examined. The chaperone may leave the room once the pelvic or female breast examination is completed and the patient is properly draped; (2) assume a supportive role in the examination, but should not interfere with physician/patient relationship; (3) preserve physician/patient confidentiality.
• The patient or Physician/Provider may request a chaperone to be present during any office examination. The chaperone may be a family member or friend of the patient or the physician/provider’s assistant.
VII. CONFIDENTIALITY OF SPECIFIED MEMBER INFORMATION AND MEDICAL RECORDS

All consultations or discussions involving a Plan member or his/her case should be conducted discreetly and professionally in accordance with professional practice and standards of ethics. All members have a right to confidentiality, and any health care professional or person who deals directly or indirectly with the member or his/her medical record must honor this right. Information regarding the member or his/her case, including medical, financial, and personal information is considered confidential and must be treated as such.

Confidential information includes:

1. Any communication between a member and a physician.
2. Any communication with other clinical persons involved in the member’s health, medical care, and mental health care, including:
   a) all clinical data, i.e., diagnosis, treatment;
   b) member transfer to a facility for treatment of drug abuse; alcoholism, and/or behavioral health problem;
   c) Any communicable disease such as Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under Federal or State law.

VIII. RELEASE OF MEMBER INFORMATION

All Plan members have the right to confidentiality. In order to protect the confidentiality of member information, Plan addresses confidentiality in all contracts. Except for the purposes of treatment, payment or operations, release of member information must be authorized by the member or the member’s authorized representative. An authorized representative is an individual designated by a member to make health care and/or personal decisions through a power of attorney, health care surrogate designation, court appointed guardianship or designation in a will for minors or incapacitated persons.

IX. REPORTING ADVERSE INCIDENTS TO PLAN

Plan has a risk management program which includes the reporting of Adverse Incidents and quality of care grievances to the Florida Agency for Health Care Administration (AHCA).

Physicians and other health care providers have an affirmative duty to report any Adverse Incident involving an Plan member occurring at their offices and outside of hospitals, outpatient ambulatory, skilled nursing, and rehabilitation facilities. Adverse Incidents occurring at hospitals, outpatient facilities and rehabilitation facilities are reported by those facilities directly to AHCA.

An Adverse Incident is an event over which health care 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. Adverse incidents include, but are not limited to:

- Death
- Brain or Spinal Injury
• Surgery on the wrong patient or wrong site
• Medically unnecessary surgery or surgery unrelated to the member’s condition/diagnosis
• Surgery to remove foreign objects left from a surgical procedure
• Surgery to repair damage from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the member and documented through the informed-consent process
• Permanent disfigurement
• Fractures or dislocation of joints or bones

In addition, participating providers should report other occurrences/events to Plan, including:

• Complication of drug, treatment, or service prescribed.
• Patient dissatisfaction angrily expressed with threats.
• Delay in diagnosis or referral.
• Breach of confidentiality.
• A request for medical records by an attorney other than for motor vehicle accident.
• Actual or potential Quality of Care issues involving a Plan member.
• Hospital-acquired infections.
• Falls occurring in contracted facilities.

**NOTE: All Occurrences should be reported to the Plan Risk Manager within three (3) business days, using the Plan Incident Report Form.**

The information submitted to Plan is used to investigate potential quality issues and for risk management review. All information reported to Plan will remain strictly confidential in accordance with Plan policies and procedures on confidentiality.

**X. FRAUD, WASTE & ABUSE**

FWA requirements for Participating providers, include, but are not limited to:

1. Helping the Plan fight FWA by notifying the FWA Department immediately if you become aware of any suspected FWA involving a Plan member, a vendor or another provider. Examples include but not limited to:
   • A member who intentionally allows others to use his/her identification card to obtain services or supplies from any Physician/Provider.
   • A member who knowingly provides fraudulent information on his/her enrollment form that materially affects the member’s eligibility.
   • A pharmacy drug shorting, switching prices, altering scripts and/or data to obtain a higher reimbursement.
   • A pharmacy dispensing counterfeit or adulterated drugs, dispensing a drug without a prescription, prescription refill errors or incurring in inappropriate billing practices, etc.
   • Theft of your DEA number or prescription pad.
   • Kickbacks, inducements and other illegal remuneration.

2. Establishing policies and procedures in place for preventing, detecting, correcting and reporting of FWA.
3. Ensuring the necessary resources to fulfill FWA obligations, training of staff and training of downstream entities on FWA in order to become acquainted with the Plan’s expectations and requirements relating to the FWA program requirements and FWA prevention, detection and correction as outlined in Training documents and Compliance and FWA materials located on the Plan’s Web Site.

4. Establishing a system in place to collect and maintain records of FWA training and reporting for a period of at least 10 years.

5. Safeguarding Doctors HealthCare Plans confidential and proprietary information.

6. Providing accurate and timely FWA information on-request in the regular course of business.

7. Performing Exclusion Checks: Screening all employees and downstream entities against federal government exclusion lists, including the Medicare Preclusion List (https://www.cms.gov/Medicare/Provider-Enrollmentand-Certification/MedicareProviderSupEnroll/PreclusionList.html), Office of Inspector General (“OIG”) list of Excluded Individuals and Entities (https://oig.hhs.gov/exclusions/exclusions_list.asp) and the General Services Administration (GSA) and Excluded Parties Lists System (https://www.sam.gov/SAM/). Anyone listed is not eligible to service Doctors HealthCare Plans members and must be removed immediately from providing services or support. The Plan must be notified immediately.

8. Monitoring staff and ensuring a strong posture against FWA as well as auditing the compliance of any subcontractors (downstream entities) that provide services to members of the Plan.

9. Ensuring that notification and authorization is obtained from Doctors HealthCare Plans prior to entering relationships with downstream entities to perform duties related to Doctors HealthCare Plan contract.

10. Doctors HealthCare Plans is required to provide CMS with specific offshore subcontractor information and complete an attestation regarding protection of beneficiary PHI.

11. Cooperating fully with any FWA investigation of alleged, suspected or detected violations.

12. Publicizing disciplinary standards to employees and downstream entities.

13. Instituting disciplinary standards and taking appropriate action upon discovery of noncompliance or FWA.

14. Reporting instances of suspected and/or detected FWA and noncompliance with the compliance policies:
   - Report issues to FWA email reportfraud@doctorshcp.com or call (833) 342-7911. This Hot Line is confidential and available 24 hours a day, 7 days a week to report FWA related matters.
   - Report issues to Compliance email (compliance@doctorshcp.com) or Compliance Help Line (833) 500-3427. The Help Line is confidential, toll-free and available 24 hours a day, 7 days a week to report violations or raise questions or concerns related to compliance. Calls may be made anonymously.

XI. COVERING PHYSICIANS

In the event a provider is on vacation, takes a sabbatical, or is temporarily unavailable to provide care or services to Plan members, they must make arrangements with another like specialty participating with Plan to provide services on their behalf. Should a provider have a covering physician who IS NOT contracted and credentialed with Plan, they must obtain an approval from Plan. The covering physician must sign an Agreement accepting the contracted Physician/Provider fees and agree not to balance bill Plan members.
XII. CLOSING OF A PHYSICIAN PANEL

A contracted Primary Care Physician desiring to close their panel for “good cause” should contact the Provider Relations Department with the following information:

- A written request, 60 days prior to the requested closing date, stating the “good cause” reason for closing a panel.
- Information regarding the status of the closed panel request for example: to new patients only or to all patients including existing patients transferring from another plan.
- A specific effective date for the re-opening of the panel if known, or description of circumstances under which panel may be re-opened.
- A PCP cannot discriminate against Doctors HealthCare Plan’s members by closing panels to our members and not all patients.

XIII. PROVIDER BILLING AND ADDRESS CHANGES

Participating Providers are required to provide thirty (30) day prior written notice to Network Development for any of the following changes:

- Tax identification number (Copy of original W-9 Form is required)
- Physical or billing address
- Group name or affiliation
- Telephone number

A thirty (30) day formal written notice will enable Plan to make changes in a timely and efficient manner while providing providers with the assistance needed to affect a smooth transition. Doctors HealthCare Plans, Inc. must update the provider directory information any time they become aware of changes.

Contracted physicians and providers will be contacted regularly or at a minimum on a quarterly basis to update the following information in provider directories:

- Ability to accept new patients;
- Street address;
- Phone number; and
- Any other changes that affect availability to patients

Updates and/or changes to a participating provider’s demographic or contractual information must be communicated to the Plan formally in writing to the following:

Doctors HealthCare Plans, Inc.
Network Development Department
2020 Ponce de Leon Blvd., PH 1
Coral Gables, FL 33134
XIV. ENCOUNTERS AND OTHER DATA

Physicians/Providers shall submit all reports and clinical information required by Plan. Capitated Physicians/Providers shall not submit claims for services set forth as capitated services but shall submit encounter information to Plan on standard CMS 1500, or its successor forms which identify the health services provided to Members and which shall also contain such statistical and descriptive medical and patient data as specified by Plan. Encounter information on capitated Covered Services shall be submitted to Plan within 30 days of the date of service to the Member.

Physicians/Providers that fail to submit encounters and other data as required by Plan on a timely manner may be subject to disciplinary actions such as implementation of corrective actions plans, monetary penalties, etc. until the data is received.

XV. ADVANCE DIRECTIVES

Advance directives are designed to enhance an incapacitated individual’s control over medical treatment and describe applicable State law concerning advance directives. The Health Plan provides written information to all members at the time of enrollment concerning their rights under the laws of the state of Florida to make decisions concerning their medical care, including their right to accept or refuse medical or surgical treatment including their right to formulate advance directives. Providers are required to comply with Federal and State statutes regarding advance directives. The member’s record must indicate whether or not the individual has executed an advance directive, and a copy of such must be retained and prominently placed as part of the medical record of the member.

XVI. PROVIDER APPEALS PROCESS

Physicians/Providers who have a complaint about Doctors HealthCare Plans, Inc., a Plan employee or member should contact their Provider Relations Representative. The Provider Relations Representatives are responsible for settling the complaint and the proper communication of such resolution to the Physician/Provider.

Similarly, if Plan receives a complaint from a member about you or your office staff, your Provider Relations Representative will contact you to discuss the member’s complaint and obtain your response. Plan has 30 days in these cases to respond to the member, so we ask for your cooperation in responding to member complaints in a timely manner; Member complaints must be given its due attention within the designated 30-day time frame.

ADMINISTRATIVE DISPUTE RESOLUTION ~ PARTICIPATING PROVIDERS

The Plan has in place a mechanism to address alleged violations of the requirements of the organization by participating providers. The mechanism in place offers disputing providers the right to consideration of a dispute by an authorized representative of the organization that was not involved in the initial decision that is the subject of dispute.

The dispute process is available to any participating provider who wishes to initiate it. The process is designed to respect the rights of providers and must also protect Plan members. Examples of administrative disputes falling within the scope of this process include, but are not limited to, failure to submit medical records in a timely manner, accessibility issues, and changes in network status for administrative reasons.

The scope of the administrative dispute process does not include medical necessity or those related to actions...
regarding quality of care and/or member safety issues or changes in participation status related to professional competency or conduct; the medical necessity appeal process and peer review processes are in place to address such disputes. Claims Disputes and related matters are addressed through the claim dispute policy and process.

Providers are encouraged to make inquiries of an appropriate department to address issues prior to submitting a dispute request, or to present the issues to the Department of Provider Relations directly if issues are not properly addressed by the corresponding department.

To submit an administrative disputes:

- The participating provider must submit an administrative review request with all complete supporting documentation within one hundred twenty (120) days of discovery of the subject of the dispute; requests may be submitted via:
  - U.S. mail, address: 2020 Ponce de Leon Blvd., PH 1, Coral Gables, FL 33134, ATTN: Provider Relations Department
  - Via Electronic Mail: www.doctorshcp.com

Supporting documentation may include written comments, documents, copies of company generated letters, or other records of facts and will be taken into account during the dispute review process.

Dispute review process:

- Disputes are examined upon receipt may be forwarded for review by Committee delegates to obtain resolution.
- Dispute committees conduct objective evaluations using all available information and make decisions in accordance with written agreements and regulatory requirements.
- Providers are notified in writing of outcomes of the review process:
  - Notification of overturned decisions, disputes found in favor of the provider, will be mailed and effectuated within 30 business days of the decision.
  - Notification when original decisions are upheld, are sent to the disputing provider within 60 calendar days of receipt of the original request.

Providers have the right to withdraw a dispute request at any time during the process; the request to withdraw the dispute must be in writing.

PRESENTING GRIEVANCES/ORGANIZATION/COVERAGE DETERMINATIONS & APPEALS

The process and procedures applicable to providers to present grievances, organization/coverage determinations and appeals follow the guidelines and provisions stipulated in 42CFR Part 422 Subpart M and 42 CFR Part 423 Subparts M and U. For your reference, additional guidance may be found in the following Centers for Medicare and Medicaid Services (CMS) webpages:

LEXICON OF APPLICABLE TERMS

Appeal: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO): Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCCQIOs review enrollee complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and enrollee.

Dismissal: A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

Independent Review Entity (IRE): An independent entity contracted by CMS to review adverse level 1 appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals.

Quality of Care Grievance: A grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.

Reconsideration: Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.

Redetermination: First level in the Part D appeal process in which the plan sponsor reviews an adverse Part D coverage determination, including the findings upon which the decision was based and any other evidence submitted or obtained.

Representative: Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D, as defined in §423.560 as “appointed representative,” an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.
ADMINISTRATIVE PROCESS
Doctors HealthCare Plans will make timely coverage decisions (initial requests and appeals) which includes soliciting
clinical information when necessary. We are only required to conduct outreach to request additional information
from a provider if we do not have all necessary information to make a coverage or appeal decision; a minimum
of one attempt to obtain additional information will be made and is considered sufficient. Coverage decisions and
Appeal requests can be dismissed by the Plan on grounds that a valid request was not received. In instances in which
the Plan pursues a dismissal, the Plan will notify the enrollee and/or the individual asserting representative status in
writing subject to 42 CFR Part 422 or 423 Subpart M.

An organization determination is any determination (i.e., an approval or denial) made by the Plan, or its
delegated entity with respect to the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post stabilization care, or
  urgently needed services;
- Payment for any other health services furnished by a provider (other than the MA plan), that the enrollee
  believes are covered under Medicare, or if not covered under Medicare, should have been furnished,
  arranged for, or reimbursed by the MA plan.
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services,
  which the enrollee believes should be furnished or arranged by the MA plan;
- Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment; or
- Failure of the MA plan to approve, furnish, arrange for, or provide payment for health care services in a
  timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely
  affect the health of the enrollee.

A coverage determination is a Plan’s decision about whether to provide or pay for a drug that an enrollee
believes may be covered by the plan sponsor, including a decision related to a Part D drug that is:

1. not on the plan’s formulary;
2. determined not to be medically necessary;
3. furnished by an out-of-network pharmacy; or
4. otherwise excluded under §1862(a) of the Act if applied to Medicare Part D.
5. A decision on the amount of cost sharing for a drug;
6. Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the
  health of the enrollee (see 40.11 for more information);
7. Whether an enrollee has, or has not, satisfied a prior authorization or other utilization
   management requirement;
8. A decision about a tiering exception request under 42 CFR §423.578(a); or
9. A decision about a formulary exception request under 42 CFR §423.578(b).

WHO MAY REQUEST AN INITIAL DETERMINATION
Health Plan Enrollees or their representatives may make a request for all types of coverage. Other parties that may
also request initial determinations for standard pre- service request, expedited requests, payment requests include
contract or non-contract provider/physician that furnishes, or intends to furnish, services to the enrollee; Staff of said
provider’s/physician’s office acting on said physician’s behalf (e.g., request is on said physician’s letterhead). For
Expedited Requests, a physician or staff of said physician’s office acting on said physician’s behalf (e.g., request is on
said physician’s letterhead). For Payment Requests, contract or non-contract providers.

For prescription drug benefits (Part D), standard or expedited requests may be presented by an enrollee’s prescribing physician or other prescriber; staff of said prescriber’s office acting on said prescriber’s behalf (e.g., request is on said prescriber’s letterhead or comes from the prescriber office fax machine). For payment requests and direct member reimbursement only an enrollee or an enrollee’s representative (which may be the prescribing physician or other prescriber) may request reimbursement under Part D.

Doctors HealthCare Plans accepts coverage requests 24 hours a day, 7 days a week (including holidays). Processing timeframes for organizational determinations and coverage determinations will be observed as follows:

### PART C

<table>
<thead>
<tr>
<th>ORGANIZATION DETERMINATIONS TYPE</th>
<th>PROCESS TIMELINE</th>
<th>EXTENSION, IF APPLICABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service</td>
<td>14 calendar days</td>
<td>28 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14-day extension if member requests extension or if Plan justifies need for additional information; See 42 CFR 568(b)(1) and (2)</td>
</tr>
<tr>
<td>Payment</td>
<td>30 days</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Contract providers payment process based on contract terms; See 42 CFR 422.520</td>
<td></td>
</tr>
<tr>
<td>Expended</td>
<td>72 hours</td>
<td>17 days</td>
</tr>
</tbody>
</table>

### PART D

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG BENEFIT COVERAGE DETERMINATIONS TYPE</th>
<th>PROCESS TIMELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>72 hours</td>
</tr>
<tr>
<td>Expedited</td>
<td>24 hours</td>
</tr>
<tr>
<td>Payment</td>
<td>14 calendar days</td>
</tr>
</tbody>
</table>

**NOTIFICATION REQUIREMENTS**

The Plan will provide verbal or written notice of all favorable pre-service approval decisions and will include any conditions of the approval, such as the duration of the approval or limitations that may apply. The notice may be sent via fax or e-mail to the provider. A written denial notice is required to be sent to the enrollee (and physician involved, as appropriate) whenever the Plan’s determination is partially or fully adverse to the enrollee.

The standardized denial notice is the Notice of Denial of Medical Coverage or Payment (Form CMS-10003-NDMCP), also known as the Integrated Denial Notice (IDN). The IDN will provide the following information:

- A specific and detailed explanation of why the medical services/items were denied, including a description of the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable;
- Information regarding the enrollee’s right to appeal and the right to appoint a representative to file an appeal on the enrollee’s behalf;
• For service denials, a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process;
• For payment denials, a description of the standard reconsideration process and timeframes, and the rest of the appeals process;
• The enrollee’s right to submit additional evidence in writing or in person; and
• An explanation of a provider’s refusal to furnish an item or service (if applicable).

Members have a right to receive notification of a decision that involves discharge from the hospital when the determination is made that inpatient care is no longer necessary. Hospitals must deliver a valid, written CMS Form R – 193. Members may request an immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) of this decision. If the enrollee does not make a timely request to the BFCC-QIO, the enrollee may contact the Plan to request an expedited reconsideration.

When a BFCC-QIO notifies the Plan that a member has requested an immediate review, Doctors HealthCare Plans must:

• Properly execute and deliver (directly or by delegation) a Detailed Notice of Discharge (DND), Form CMS-10066, to the enrollee as soon as possible, but no later than noon of the day after the BFCC-QIO’s notification.
• Ensure delivery of the DND, regardless of whether it has delegated that responsibility to its providers.
• At an enrollee’s request, the Plan must deliver to the enrollee a copy of any documentation that it sends to the BFCC-QIO, including written records of any information provided by telephone. This documentation must be delivered to the enrollee no later than close of business of the first day after the material is requested.
• Provide, directly or by delegation, all information that the BFCC-QIO needs to make its determination, including copies of the IM and the DND (if applicable). This information must be delivered as soon as possible, but no later than noon of the day after the BFCC-QIO notifies Doctors HealthCare Plans of the enrollee’s request.

Note: The delegation of notice delivery or other functions is determined by the contract between Doctors HealthCare Plans and its providers. The BFCC-QIO determines whether the Plan and the hospital should make the information available by telephone or in writing.

Doctors HealthCare Plans is financially responsible for the continued coverage of services during the BFCC-QIO review, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers. Participating Hospitals and Critical Access Hospitals (CAHs) must follow the guidance for hospitals and CAHs found in Chapter 30 of the Medicare Claims Processing Manual.

For additional guidance regarding responsibilities of the BFCC-QIO, please see §422.622(d).

Plan members also have the right to request an immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) when a SNF, HHA, or CORF decides to terminate previously approved coverage. Members receiving covered services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC), delivered by the facility or provider, before their services end.

The process for notification of all favorable standard determinations applicable to Part D must be in writing and must,

• Explain the conditions of the approval.
• Include the conditions, duration of an approval;
• Limitations associated with an approval; and/or
• Any coverage rules applicable to subsequent refills.

Denials of requests in whole or in part for Part D services must be communicated in writing through the Notice of Denial of Medicare Prescription Drug Coverage, Form CMS-10146.

RECONSIDERATIONS AND REDETERMINATIONS (LEVEL 1 APPEALS)
A party for purposes of an appeal of an adverse initial determination has a right to a reconsideration (Part C) or redetermination (Part D) by the Plan. A reconsideration or redetermination (hereinafter referred to as a level 1 appeal) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.

It is important to note that contracted providers, including subcontracted entities, do not have appeal rights under the provisions in this guidance. Any provider disputes concerning payment denials which are presented to the Plan by contracted providers will be reviewed by the appeals/dispute procedures described in this Section in the chapter entitled “Administrative Dispute Resolution ~ Participating Providers” and in Section 7, Claims, in the chapter entitled “Claims Disputes.”

XVII. PRIVACY AND CONFIDENTIALITY OF MEMBER MEDICAL RECORDS

Physicians/Providers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records. Physicians/Providers must assure that all individually-identifiable member information, whether verbal, written, recorded or otherwise, is reported as confidential information to the extent confidential treatment is provided under State and Federal laws. Such information is protected in accordance with relevant Federal Laws such as Standards for Privacy of Individually-Identifiable Health Information, and all other State statutes, whenever releasing or disclosing any portion of a member’s medical information to any party outside of Plan, including to the member.

XVIII. OTHER REGULATORY REQUIREMENTS, PLAN POLICIES AND STANDARDS

Providers must comply with Doctors HealthCare Plans policies and procedures, Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by Doctors HealthCare Plans, CMS and/or its designees and will cooperate, assist, and provide information as requested. Providers must also maintain records a minimum of 10 years.

Doctors HealthCare Plans must include certain MA-related provisions in the policies and procedures that are distributed to network providers. 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>Contract Requirements Through Policies, Standards &amp; Manuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguard privacy and maintain records accurately and timely</td>
</tr>
<tr>
<td>Permanent “out of area” members to receive benefits in continuation area</td>
</tr>
<tr>
<td>Prohibition against discrimination based on health status</td>
</tr>
<tr>
<td>Pay for emergency and urgently needed services</td>
</tr>
<tr>
<td>Pay for renal dialysis for those temporarily out of a service area</td>
</tr>
<tr>
<td>Direct access to mammography and influenza vaccinations</td>
</tr>
<tr>
<td>No copay for influenza and pneumococcal vaccines</td>
</tr>
<tr>
<td>Agreements with providers to demonstrate “adequate” access</td>
</tr>
<tr>
<td>Direct access to women’s specialists for routine and preventative services</td>
</tr>
<tr>
<td>Services available 24hrs/day, 7 days/week</td>
</tr>
<tr>
<td>Adhere to CMS marketing provisions</td>
</tr>
<tr>
<td>Ensure services are provided in a culturally competent manner</td>
</tr>
<tr>
<td>Maintain procedures to inform members to follow-up care or provide training in selfcare as necessary</td>
</tr>
<tr>
<td>Document in a prominent place in medical record if individual has executed advance directives</td>
</tr>
<tr>
<td>Provide services in a manner consistent with professionally recognized standards of care</td>
</tr>
<tr>
<td>Continuation of benefits provisions (may be met in several ways, including contract provision)</td>
</tr>
<tr>
<td>Payment and incentive arrangements specified</td>
</tr>
<tr>
<td>Subject to applicable Federal laws</td>
</tr>
<tr>
<td>Disclose to CMS all information necessary to (1) Administer &amp; evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services</td>
</tr>
<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>
</tr>
<tr>
<td>Submission of data, medical records and certify completeness and truthfulness</td>
</tr>
<tr>
<td>Comply with medical policy, QI and MM</td>
</tr>
<tr>
<td>Disclose to CMS quality and performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years</td>
</tr>
<tr>
<td>Disclose to CMS quality and performance indicators for the benefits under the plan regarding enrollee satisfaction</td>
</tr>
<tr>
<td>Disclose to CMS quality and performance indicators for the benefits under the plan regarding health outcomes</td>
</tr>
<tr>
<td>Notify providers in writing for reason for denial, suspension and termination</td>
</tr>
</tbody>
</table>

422.118
422.54(b)
422.110(a)
422.100(b)
422.100(b)(1)(iv)
422.100(g)(1)
422.100(g)(2)
422.112(a)(1)
422.112(a)(3)
422.112(a)(7)
422.80(a), (b), (c)
422.112(a)(8)
422.112(b)(5)
422.128(b)(1)(ii)(E)
422.504(a)(3)(iii)
422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
422.208
422.504(h)
422.64(a);
422.504(a)(4)
422.504(f)(2)
422.111(e)
422.301(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(1)(3)
422.202(b);
422.504(a)(5)
422.504(f)(2)iv(A)
422.504(f)(2)iv(B)
422.504(f)(2)iv(C)
422.202(c)(1)
XIX. HOLD HARMLESS

Providers must hold Plan members harmless for payment of fees that are the legal obligation of Doctors HealthCare Plans. Such provision will apply, but will not be limited to insolvency of the MA organization, contract breach, and provider billing:

- Contracts must contain accountability provisions specifying:
  1. That first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years;
  2. That the Plan oversees and is accountable to CMS for any functions and responsibilities described in the MA regulations (422.504(i)(4)(iii)); and
  3. That if the Plan chooses to delegate functions that it must adhere to the delegation requirements — including all provider contract requirements in these delegation requirements — described in the MA regulations (422.504(i)(3)(iii); 422.504(i)(4)(i)-(v)).

- Contracts must specify that providers agree to comply with the Plan’s policies and procedures.

XX. PROVIDER MARKETING

These guidelines are intended to serve as a general summary of applicable laws, rules and regulations, CMS guidance, and Doctors HealthCare Plans, Inc. policies. For specific guidance on provider activities related to Medicare plans, please refer to the CMS Medicare Managed Care Manual, Medicare Communications and Marketing Guidelines section 60 for more detailed information. Providers must receive plan approval prior to sending any communications that reference Doctors HealthCare Plans, Inc. to patients or prospective patients. Furthermore, providers may not engage in any activities with respect to Doctors HealthCare Plans without prior written approval.

The term “provider” refers to all providers contracted with Doctors HealthCare Plans and their subcontractors, including, but not limited to: pharmacists, pharmacies, physicians, hospitals and long-term care facilities.

CMS is concerned with providers engaging in plan marketing activities because:

- Providers may not be fully aware of all plan benefits and costs
- Providers may face conflicting incentives if they act as agents of a plan instead of in the best interest of their patients
Any provider (and/or subcontractors) contracted with Doctors HealthCare Plans, Inc. must comply with the following:

**ACTIVITIES AND MATERIALS IN A HEALTH CARE SETTING:**

To maintain appropriate beneficiary safeguards while not impeding the provider/patient relationship, CMS distinguishes between provider-initiated activities and plan-initiated activities in a health care setting. To this end, providers may engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options. Providers must remain neutral in assisting beneficiaries with enrollment decision.

Providers are permitted to make available and/or distribute plan marketing materials, as long as the provider and/or facilities distributes or makes available plan marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if providers agree to make available and/or distribute plan marketing materials, they should do so knowing they must accept future requests from other plans with which they participate. Providers also are permitted to display plan posters or other plan marketing materials in common areas such as, common entryways, vestibules, waiting room, hospital or nursing home cafeterias, and community, recreational or conference room.

Doctors HealthCare Plans and Doctors HealthCare Plans sales agents may conduct sales activities, including sales presentations, distribution of marketing materials, and collection of enrollment forms in common areas of health care settings. Common areas where marketing activities are allowed include, but are not limited to, common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, community or recreational rooms and conference rooms. If a pharmacy counter is located within a retail store, common areas would include where patients interact with pharmacy providers and obtain medications. Communication materials, as defined in the Medicare Managed Care Manual, may be distributed and displayed in all areas of the health care setting.

Doctors HealthCare Plans and Doctors HealthCare Plans sales agents may not market in restricted areas. Restricted areas generally include, but are not limited to, exam rooms, hospital patient rooms, treatment areas where patients interact with a provider and his/her clinical team and receive treatment (including dialysis treatment facilities), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications. These restrictions also apply to activities planned in these settings outside of normal business hours.

Plans are permitted to schedule appointments only with beneficiaries residing in a long-term care facility upon request by the beneficiary.

**Provider-Initiated Activities:**

Provider-initiated activities are those conducted by a health care professional, including pharmacists, at the request of the patient or as a matter of a course of treatment, when meeting with the patient as part of the professional relationship between health care provider and patient. Provider-initiated activities do not include those conducted at the request of the Plan/Part D sponsor or pursuant to the network participation agreement between the Plan/Part D sponsor and the provider.

**Permissible contracted provider-initiated activities include:**

- Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from https://www.medicare.gov) including in areas where care is delivered.
• Providing the names of Plans/Part D sponsors with which they contract and/or participate.

• Answering questions or discussing the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered)

• Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Office, CMS’ website at https://www.medicare.gov, or (800) MEDICARE; Referring patients to Plan marketing materials available in common areas; and Providing information and assistance in applying for the LIS.

Plan Initiated Provider Activities in a Health Care Setting:

CMS defines plan-initiated activities as those activities where either a Plan/Part D sponsor requests contracted provider to perform a task or the provider is acting on behalf of the Plan/Part D sponsor. For the purpose of plan-initiated activities, the Plan/Part D sponsor must ensure compliance with requirements applicable to communication and marketing.

Plan/Part D sponsor requests for providers to discuss benefits and cost sharing would fall under the definition of marketing and are hence prohibited from taking place where care is being delivered.

Plans/Part D sponsors may not allow contracted providers to:

• Accept/collect scope of appointment forms
• Accept Medicare enrollment applications
• Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider
• Mail marketing materials on behalf of Plans/Part D sponsors
• Offer inducements to persuade their patients to enroll in a particular plan or organization;  
• Conduct health screenings as a marketing activity
• Distribute marketing materials/applications in areas where care is being delivered

Offer anything of value to induce enrollees to select them as their provider; or Accept compensation from the plan for any marketing or enrollment activities

Plans/Part D sponsors may allow contracted providers to:

• Make available, distribute, and display communication materials, including in areas where care is being delivered
• Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms)

Provider and Plan Joint Events:

Providers may invite contracted plans to conduct educational seminars or marketing events. All CMS guidance around health plan sales and marketing events, as well as health plan educational events hosted within provider settings, and Doctors HealthCare Plans policies, standards and procedures, must be followed. All contracted plans must be permitted to participate upon request.
In addition:

- There must be a clear separation between the plan’s activities and the provider’s activities. It must be clear to an attendee whether the provider or the plan is the host of the provider-plan event. Some relevant factors in determining which party is hosting the event include which party moderates the event, organizes the event, welcomes attendees and makes up the majority of the agenda.
- Funding for the event should be proportionate to the level of participation by each party and in all cases must be commensurate with the fair market value of that participation.
- Providers must not market the plan and the plan must not market providers, and there cannot be an understanding that such activity will occur in the future.
- If the plan conducts any marketing activities at the seminar, all CMS regulations around plan sales events and plan marketing in provider settings must be followed.
- Plans may conduct marketing activities only in common areas where patients do not primarily receive health care services or are waiting to receive health care services.
- Meals cannot be served at a plan marketing or sales event.
- Health screenings cannot take place at a plan marketing or sales event.
- Attendees cannot be required to provide any contact information as a prerequisite for attending.
- If a raffle or drawing is conducted, contact information obtained from attendees cannot be used for any other purpose than to notify the winner of the raffle or drawing.
- Any gifts, giveaways, prizes, refreshments, food or promotional activities must meet CMS and OIG requirements.

Outlined below are general do’s and don’ts to assist you in achieving and maintaining compliance with CMS requirements.

**DON’Ts:**

- DO NOT make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in or select a specific plan based on financial or any other interests.
- DO NOT offer anything of value to induce enrollees to select you as their physician or health care provider or to enroll in a particular plan or organization.
- DO NOT mail marketing materials on behalf of a plan.
- DO NOT conduct health screenings as a marketing activity.
- DO NOT accept compensation directly or indirectly from a plan for beneficiary enrollment activities or offer/accept financial incentives to/from sales agents.
- DO NOT accept or collect sales appointment forms (scope of appointment).
- DO NOT accept or assist beneficiaries to complete Medicare enrollment applications.
- DO NOT distribute marketing materials/applications in areas where care is being delivered.
- DO NOT advertise non-health items or services as plan benefits (e.g., computer, citizenship or English classes).
DO’s:

• DO provide the names of all plan sponsors with which you contract and/or participate.
• DO provide information and assistance in applying for the low-income subsidy (LIS).
• DO answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (may occur in areas where care is delivered). NOTE: Plan/Part D sponsor requests for providers to discuss benefits and cost sharing would fall under the definition of marketing and are hence prohibited from taking place where care is being delivered.
• DO refer patients to plan marketing materials and enrollment forms available in common areas, as long as you do so for any contracted plan sponsor, upon request.
• DO make available, distribute, and display communication materials, including in areas where care is being delivered, as long as you do so for any contracted plan sponsor, upon request.
• DO provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational, or conference rooms).
• DO refer your patients to other sources of information, such as state health insurance assistance programs (SHIPs), plan marketing representatives, state Medicaid offices, the local Social Security office, the CMS website or 1-800-MEDICARE (1-800-633-4227).
• DO distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare and You” handbook or “Medicare Options Compare” (from www.medicare.gov), including in areas where care is delivered.

Provider Affiliation Information:

Providers may announce new affiliations and continuing affiliation announcements for a specific plan once a contractual agreement between the Plan/Part D Sponsor and provider has been agreed upon by both parties. Affiliation announcements may be made through direct mail, email, phone or advertisement. Providers must submit affiliation announcements to Doctors HealthCare Plans for review and approval prior to distribution, or use pre-approved templates provided by Doctors HealthCare Plans without any alterations. Affiliation announcements must clearly state that the provider also may contract with other health plans. These announcements are considered communication materials. Any provider affiliation announcement materials that include additional information, such as plan benefits, premiums or cost sharing, are considered marketing materials and cannot be mailed by providers on behalf of the plan.
Credentialing is the process by which the appropriate peer review bodies evaluate each individual Physician’s and/or Provider’s experience, background, training, demonstrated ability, licensure, and health status. In order to become part of the network and provide services to Plan members, a Physician and/or Provider must go through the credentialing process.
I. INITIAL CREDENTIALING

All contracted professionals must be credentialed in order to participate with Plan. Additionally, the following list of Health Care Professionals must complete credentialing, either directly or through a delegated agreement, in order to participate:

- Physicians (MD, DO)
- Podiatrists (DPM)
- Dentists (DDS, DMD)
- Advanced Registered Nurse Practitioners (ARNP)
- Physician Assistants (PA)
- Certified Nurse Midwife (CNM) (If Applicable)
- Certified Nurse Anesthetists (CNA)
- Certified Registered Nurse Anesthetists (CRNA)
- Physical Therapist (PT)
- Occupational Therapist (OT)
- Speech/Language Pathology (SLP)
- Respiratory Therapist (RT)
- Optometrist (OD)
- Psychologist (PhD)
- Licensed Clinical Social Worker (LCSW)
- Masters in Social Work (MSW)
- Licensed Mental Health Counselor (LMHC)
- Chiropractors (DC)

The following entities will also be credentialed:

- Hospitals
- Ambulatory Surgery Centers (ASC)
- Skilled Nursing Facilities (SNF)
- Independent Diagnostic Testing Facilities (IDTF)
- Inpatient Hospice
- Audiology Centers
- Behavioral Health Facilities
- Clinical Laboratory Facilities
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Dialysis Centers
- Durable Medical Equipment Facilities (DME)
- Home Health Agencies
- Inpatient and Outpatient Services Centers
Please Note: Existing contracted individual physicians and group practices that add physicians must ensure that the new physician(s) are credentialed prior to providing services to Plan members.

The Provider will complete an approved Plan specific application or Council for Affordable Quality Healthcare (CAQH) application and attach current supporting documentation. Incomplete applications can be returned or if not signed and attested. Plan will obtain information regarding the applicant from the FL Department of Health, Drug Enforcement Administration, Board certification (as applicable), CMS Preclusion list, Medicaid/Medicare sanctions, System for Award Management (SAM), Office of Inspector General (OIG), and Office of Foreign Asset Control (OFAC).

The Provider must respond to any reasonable Plan request for additional information, including but not limited to, Drug Enforcement Administration (DEA) verification, and a site inspection evaluation. If the information requested is not received within ninety (90) calendar days from receipt of the completed application, and a “good faith” effort was made by Plan to obtain and verify the information, the application will be removed from consideration and the process will terminate.

Plan recognizes the Physician’s/Provider’s right to review information that is submitted in support of the credentialing application to the extent permitted by law. The Physician/Provider will be notified if any information obtained during the review differs substantially from the information provided by the Physician/Provider. The Physician/Provider has the right to correct any erroneous information received by Plan except NPDB and Peer Review reports.

No Practitioner or Group shall be denied a contract with the Plan or have any such contract terminated on the basis of race, color, religion, age, sex, marital status, political association, national origin, or handicap; and not to discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision (§422.205).

Providers may obtain information regarding the status of their credentialing application by calling the Plan Credentialing Department. Information regarding general requirements for participation may also be obtained.

The entire process, including signature on application and attestation as well as verifications, must be completed within one hundred-eighty (180) calendar days prior to credentialing decision. All documents printed from the Internet or received electronically from any source must be dated and initialed by the Credentialing staff. Documentation of verifications obtained by phone will be noted on the checklist, dated and initialed by the Credentialing staff. The credentialing process includes, at a minimum, the following primary source verifications:

- Verification through the on-line program with the State Medical Board (http://www.doh.state.fl.us/mqa/) confirming that the applicant has a valid medical license in good standing. Licensure must be current at time of the credentialing decision.
- Written verification of copy of DEA Certificate, if applicable. Certification must be current at the time of the
credentialing decision. The Credentialing Committee will review any restrictions to the DEA Certificate.

- If the physician is not board certified, written verification of the highest level of training completed will be obtained directly from the school or programs or through the use of industry-recognized verification sources (ABMS, AMA, AOA or specific Board); Plan accepts organizations recognized by regulatory agencies and, NCQA, AAAHC, TJC and URAC.
- Curriculum Vitae or summary of work for minimum of five (5) years. The applicant must explain in writing any gaps greater than six (6) months in the work history in writing.
- Verification of professional liability claims history for previous five (5) years must be obtained by accessing the National Practitioner Data Bank.
- Written documentation from the applicant explaining circumstances surrounding malpractice claims is requested as part of the application. The documentation is reviewed to determine if additional information may be required.
- Written verification of previous or current sanctions, restrictions, and limitations on scope of practice by accessing the NPDB or the Department of Health’s (DOH) on-line license verification system at (http://www.doh.state.fl.us/mga).
- Verification of applicant’s Medicare and Medicaid provider status by accessing the NPDB.

II. RE-CREDENTIALING

Re-credentialing is conducted every three years in accordance with Plan policies and procedures. Three months prior to the Provider’s re-credentialing date, a re-credentialing application form or letter explaining the steps they must take will be sent to the Physician/Provider. The Physician/Provider has thirty (30) calendar days from the mailing date to return the completed application and requested documentation.

If a Provider fails to submit a completed re-credentialing application and documentation before his/her credentialing expiration date, the Provider Relations Department staff will attempt to secure a completed re-credentialing application and the requested documents for purposes of re-verification. A completed re-credentialing application must be secured for the Physician/Provider to maintain Plan privileges. The Provider may not provide services to Plan members if he/she is not credentialed or re-credentialed by Plan. The Physician’s/Provider’s application and the results of specific performance data completed by Plan, in areas of member satisfaction, clinical outcomes an peer review activities, are reviewed by the Plan Credentialing Committee.

The Committee will deny, modify, or approve continued credentialing of the physician for another credentialing period of three years or less. Upon re-credentialing the provider is considered to be re-credentialed unless otherwise notified. Plan offers a hearing procedure to Physicians/Providers denied for quality of care issues.

III. SITE REVIEW VISIT

As part of the credentialing process, Plan requires precontractual site inspection evaluations be performed by a Provider Relations Representative or other designated Plan staff member authorized to conduct a site inspection evaluation for each practice site location associated with a PCP, OB/Gyn and/or high-volume specialist.

When reviewing the office or facility of a participating provider, Plan will ensure that the review is conducted by a Plan representative who:
• Carries a picture ID with his/her full name;
• Carries identification that includes the Plan name and logo;
• Relies on a site inspection evaluation review tool that clearly defines the criteria to conduct an onsite review to address at least the following:
  – Patient access, including physical access for the disabled and access to appointments and to medical advice in a timely manner;
  – The office’s public health policies and procedures concerning infection control, hazardous materials, and medication; and
  – The office’s safety standards concerning policies and procedures for fire safety, emergency procedures, laboratory, and medical equipment maintenance.
• Conduct a review of a random sample of at least one Plan member’s medical record to ensure:
  – Organization, completeness, and consistency in format;
  – Evidence of proper documentation;
  – Relevant information concerning patients’ history, diagnosis, treatment, and allergies.

IV. PLAN CREDENTIALING COMMITTEE

The Plan Credentialing Committee is a standing sub-committee of the Plan Quality Committee, with operational support from the Credentialing Department. The Plan Credentialing Committee evaluates new Physicians/Providers entering the Plan network (initial credentialing) and those presently in the network (re-credentialing) against Plan standards, guidelines, policies and procedures. The functions of the Committee include credentialing, ongoing and periodic performance assessment, re-credentialing, and establishment of credentialing and re-credentialing policies and procedures for Plan. The Credentialing Committee meets no less than six times per year for purposes of initial credentialing and re-credentialing.

V. PROVIDER TERMINATION

Either Provider or Plan may terminate the Plan Participating Provider Agreement without cause by giving the other party written notice of termination at any time at least 60 days prior to the effective date of termination, unless otherwise specified contractually in the Participating Provider Agreement with the Plan.

Doctors HealthCare Plans, Inc. has to notify its affected enrollees of the Provider’s termination 30 calendar days before the termination effective date who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Doctors HealthCare Plans considers “enrollees who are patients seen on a regular basis by the provider whose contract is terminating” to be “affected enrollees.” An “affected enrollee” is an enrollee who is assigned to, currently receiving care from, or has received care within the past six months from a provider or facility being terminated. In instances of a Primary Care Physician termination, the Plan’s members must be transferred to another PCP’s in the Plan’s network; therefore, we ask for your cooperation in adhering to the 60-day advance notice if you intend to leave our Plan. The Plan must ensure continuity of care and integration of services through arrangements with providers that will offer each member who may be affected by a termination with an ongoing source of primary and specialty care.

All other terminations are addressed in the Plan participating provider agreement, unless superseded by applicable
federal or state laws, rules and regulations.

The Plan will follow the specific requirements applicable to suspension, termination, or non-renewal of Physician contracts as indicated in the Medicare Managed Care Manual Chapter 6 Relationship with Providers.

- Must give the affected physician written notice of the reason for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the number and mix of physicians needed by the Health Plan.
- Must allow the physician to appeal the action, and give the physician written notice of his/her right to a hearing and the process and timing for requesting a hearing.
- Must ensure that the majority of the hearing panel members are peers of the affected physician.

Affected Physicians have the right to appeal by sending a written request for appeal to the address of notice in the Agreement within fifteen (15) business days of the letter of notification. The appeal process includes a right to a hearing panel, the majority of which will be the physician’s peers. Such hearing will be conducted within twenty (20) business days following receipt of appeal.

VI. PROVIDER TERMINATION APPEALS PROCESS

Physicians have termination appeal rights; this does not apply to Ancillary Service Providers, Hospitals and/or other health care practitioners. Physician have the right to appeal Plan termination notice by submitting a letter in writing within five (5) business days of receipt of termination notice. Address to:

Doctors HealthCare Plans, Inc., Inc.
Attention: VP Network Development
2020 Ponce de Leon Blvd., PH 1
Coral Gables, FL 33134
(786) 578-0965

When a termination appeals letter is received and acknowledged, Plan will schedule a meeting and the Physician/Provider will be notified in writing or telephonically of the date/time of the scheduled meeting.

Physician/Provider will be notified in writing of the appeal hearing decision.
A major goal of Plan is to provide prompt and accurate processing of claims within the specified “Prompt Payment” regulatory timeframes §422.520. As a participating provider, payment for the provision of covered services are subject to the prompt payment terms and conditions stipulated in the Participating Provider Agreement and the Provider Manual. DHCP must also make timely and reasonable payment to or on behalf of the Plan’s enrollee for the following services obtained from nonparticipating providers and suppliers:

(i) Ambulance services dispatched through 911 or its local equivalent as provided in §422.113.
(ii) Emergency and urgently needed services as provided in §422.113.
(iii) Maintenance and post-stabilization care services as provided in §422.113.
(iv) Renal dialysis services provided while the enrollee was temporarily outside the plan’s service area.
(v) Services for which coverage has been denied by the MA organization and found (upon appeal under subpart M of this part) to be services the enrollee was entitled to have furnished, or paid for, by the MA organization.

The information that follows contains the Plan’s instructions for filing a clean claim. Providers must follow these instructions to have their claims considered “clean” by Plan. Claims not meeting the definition of a clean claim may either be rejected or denied. Resubmission of rejected claims is subject to timely filing requirements. Appeals to denied claims are subject to appeal filing requirements. You are ultimately responsible for the accuracy of claims filed for your services. We respectfully recommend that your office set a policy to ensure that all necessary information is included on the initial claim submission and that the information is correct.

It is important to note that there is other Insurance Primary to Medicare and as such there are circumstances under which the Plan’s payment may be secondary to other insurance; These may include:

- Group Health Plan Coverage
- Working Aged;
- Disability (Large Group Health Plan); and
- End Stage Renal Disease;
- No Fault and/or Other Liability; and
- Work-Related Illness/Injury:
  - Workers’ Compensation Medicare Set-Aside Arrangements (WCMSA)
  - Workers’ Compensation;
  - Black Lung; and
  - Veterans Benefits

NOTE: Please be advised that Plan may have delegated arrangements with certain provider groups, for which there may be a different process, form or steps to take other than outlined here for Plan in cases of prior authorization requests or claims submissions.

Clean Claim Definition:

A “clean” claim is one that does not require the Plan to investigate or develop external to their Medicare operation on a prepayment basis. A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.

To meet the Plan’s definition of a “clean claim” a claim must:

- Pass all edits;
- Claims sent electronically to Doctors HealthCare Plans must abide by the HIPAA standards. More information about HIPAA can be found at www.cms.gov, under the “Regulations and Guidance” tab.
- Not require external development (i.e., are investigated within the claims, medical review, or payment office without the need to contact the provider, the beneficiary, or other outside source)
- Complete all required fields with accurate and valid information on a current CMS 1500 or UB-04 claim form or their successor as may be applicable to provider type or as in a format required for electronic submission;
• Be complete, legible (typed or computer generated) and accurate. The quality of paper claims submissions should enable scanning by Plan and meet Optical Character Recognition (OCR) requirements;

Claims not meeting required criteria are not considered clean claims. Depending upon the type of information missing or invalid, claims are either rejected and will require resubmission or are denied and will require appeal.

Provider Billing and Required Information:
The following data must be valid and included on every CMS 1500 claim form:

- Member’s/patient’s plan ID number (field 1a)
- Patient’s name (field 2);
- Patient’s date of birth and gender (field 3);
- Member’s name (field 4);
- Patient’s address (street or P.O. Box, city, zip) (field 5);
- Patient’s relationship to enrollee (field 6);
- Member’s address (street or P.O. Box, City, Zip Code) (field 7);
- Whether patient’s condition is related to employment, auto accident, or other accident (field 10);
- Member’s Primary Insurance Carrier
- Member’s birth date and gender (field 11a)
- Insurance carrier name (field 11c)
- Disclosure of any other health benefit plans (field 11d); If yes, COMPLETE 9, 9A, AND 9D
- Patient’s or authorized person’s signature or notation that the signature is on file with the physician or provider (field 12);
- Patient’s or authorized person’s signature or notation that the signature is on file with the physician or provider (field 13);
- Date of current illness, injury, or pregnancy (field 14);
- First date of previous, same or similar illness (field 15);
- Name of referring provider or another source (field 17);

Additionally, enter one of the following qualifiers as appropriate to identify the role that this physician (or non-physician practitioner) is performing:

<table>
<thead>
<tr>
<th>QUALIFIER</th>
<th>PROVIDER ROLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN</td>
<td>Referring Provider</td>
</tr>
<tr>
<td>DK</td>
<td>Ordering Provider</td>
</tr>
<tr>
<td>DQ</td>
<td>Supervising Provider</td>
</tr>
</tbody>
</table>

Enter the qualifier to the left of the dotted vertical line on item 17

- Referring provider NPI number (field 17b)
- Authorization Number issued by the Plan as may be required for covered services (Field 19)
- Diagnosis codes or nature of illness or injury, current ICD-10 codes (field 21);
- Date(s) of service (field 24A);
- Place of service codes (field 24B);
• EMG – emergency indicator (field 24C);
• Procedure/modifier code (current CPT or HCPCS codes are required) (field 24D);
• DX Pointer – diagnosis code by specific service (field 24E);
• Charge for each listed service (field 24F);
• Number of days or units (field 24G);
• Rendering provider NPI (field 24J);
• Physician’s or provider’s federal taxpayer ID number (field 25);
• Total charge (field 28);
• Signature of physician or provider that rendered service, including indication of professional license (e.g., MD, LCSW, etc.)
• Name and address of facility where services rendered (field 32);
• The service facility Type 1 NPI (if different from main or billing NPI) (field 32a);
• Physician’s or provider’s billing name and address (field 33); and
• Main or billing Type 1 NPI number (field 33a).

1. Do not submit black CMS-1500 forms. This includes submitting copies or carbon copies. Always submit a RED CMS-1500 form.
2. Do not write or stamp information in red ink. Information in red will not show up on the image and will not be available during processing.
3. Do not use light print or a dot matrix printer which causes broken lines. Check to make sure the ink is dark. Laser or inkjet printers are preferred.
4. Do not use small font type and size. For best processing results we recommend font type Lucida Console and size 10.
5. Do not use handwriting. It may be too light or simply unrecognizable.
6. Do not highlight items on the CMS-1500 form or attachments. This will cause the claim to be illegible which slows down the processing of the claim and may cause processing errors.
7. Do not use stamps or stickers within the body of the claim. If you must use a stamp or sticker, put it at the top of the claim within the blank area.
8. Do not leave block 11 blank. If no primary insurance exists, enter “NONE” in the field.
9. Do not use extra verbiage within the body of the claim. If you must put extra verbiage on the claim, use block 19 or an attachment.
10. Do not put a description next to the diagnosis code in block 21. All that is needed is the ICD-10 alpha/numeric diagnosis code.
11. Do not submit more than 12 diagnosis codes within block 21.
12. Do not submit more than one diagnosis pointer in block 24e. Only the first pointer will be used for processing.
13. Do not submit more than six service lines within block 24.
14. Do not put a description of the HCPCS procedure codes or times/units underneath the line item in blocks 24a – 24j. It is not needed and may cause processing errors.
15. Do not place the number of units/days in block 24g too close to the charges in 24f. This may cause the
units/days to be read as a part of the submitted charges and the number of units/days to default to 1. Right justifying the days/units in block 24g will give more space between the two fields.

16. The supplier signature in block 31 must be that of an individual, not a company name.

All institutional providers must submit institutional paper claims using the UB-04 (CMS 1450) claim form.

II. PROVIDER IDENTIFICATION (ID) NUMBER REQUIREMENTS

The NPI number and Tax ID number will be required on all claims submitted to Plan.

- Electronic CMS-1500 Claims: Include the provider number in Field FA0-23 of the NSF format or NM109, element 67 in ANSI.
- Electronic UB-04 (CMS 1450) Claims: Include the provider number in Field FA0-23 of the NSF format or NM109, element 67, in ANSI.

You may refer to www.cms.gov/Regulations-and-Guidance/Guidance for the guidance on the completion and requirements of UB – 04 (CMS1450) claim form:

III. ELECTRONIC CLAIMS SUBMISSION

Advantages to Electronic Claim Filing:
Plan encourages filing claims electronically. Benefits of filing via electronic media include:

- Decrease in turnaround time for payment;
- Streamlines the billing process;
- Reduction in Costs for Filing (i.e. postage costs, forms cost, printing costs, labor);
- Confirmation of Receipt;
- Prompt Identification of omitted/incorrect information;
- Ability for Provider to quickly track number of rejected versus accepted claims;

Claims Clearinghouse:
The Plan can receive claims electronically and we encourage you submit your claim or your encounter as such. You may call the plan directly for assistance with setting up your account for electronic claims submission or for technical support if you have any questions or problems.

Submission Process:
- Contract with a clearinghouse.
- Request your clearinghouse to send your claims to Plan via Availity
- Your clearinghouse reformats the claims and sends it to us as an electronic file, which goes directly to our claims payable computer system.
- The claim is evaluated for compliance standards.
- Electronic acknowledgements are sent to the clearinghouse.
• The claim is sent through all the data edits.
• Once the claim passes all edits it will be sent for adjudication.
• Any rejected claims are the responsibility of the provider and will not be worked until resubmitted with the specific corrections outlined in the rejection.

Transmission Frequency:
Electronic claims can be transmitted daily; however, claims transmitted on Saturday, Sunday and legal holidays are not downloaded into Plan claims processing system until the following business day.

IV. PAPER CLAIMS SUBMISSION

Plan will not accept super-bills or similar submissions as valid claims. **Claims must be computer generated or typed (not handwritten).**

Claim Signature Requirements:
When filing a paper claim, the physician or provider’s handwritten signature (or signature stamp) must be in the appropriate block of the claim form (box 31).

**Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim and the timely submission of such for payment.**

Initials are only acceptable for first and middle names. The last name must be spelled out.

Claims prepared by computer billing services or office-based computers may have “Signature on File” in the signature block along with the printed name of the provider. For claims prepared by a billing service, the billing service must retain a letter or agreement on file from the provider authorizing the service.

**Where to Submit Paper Claims:**

For paper claims from providers, mail to:

Doctors HealthCare Plans, Inc.
Claims Department
P.O. Box 132
1825 Ponce de Leon Blvd.
Coral Gables, FL 33134

V. CODING

Plan requires use of standard current CPT, ICD-10, and HCPCS coding, unless otherwise directed by Plan as outlined in this manual or participating provider contract.

Diagnosis codes should be billed with the highest degree of specificity. Use fourth and fifth digits whenever applicable. If a diagnosis code requires a fourth or fifth digit, and is not coded as such, the claim will be denied.
New and Deleted Codes:
Providers must bill for services using valid current CPT, ICD-10 and HCPCS codes and modifiers that are appropriate for the service provided. Annually, as CPT and HCPCS codes are added and deleted from the American Medical Association (AMA) and CMS listings of valid codes, Plan policy will be as follows:

- New codes may be accepted by Plan beginning one (1) month before the date on which they become effective.
- Deleted codes are not accepted. Services coded with deleted codes will be denied.
- Plan will only accept HIPAA approved code sets.

Unlisted Codes:
Plan will accept a provider’s use of an unlisted code only when there is no valid CPT or HCPCS code available, or an authorization has been obtained for use of an unlisted code or when the physician/provider’s contract with Plan specifically requires use of the unlisted code. Except as noted above, any claim submitted for a service that is CPT coded as an “unlisted” procedure or service must be filed with a detailed description of the procedure or service being billed. Failure to provide a description will result in the claim being denied. Additional documentation may be requested if the description provided is not sufficient.

For unlisted supplies (e.g., HCPCS code EL399), the claim should include a detailed description of the supply. The description can be typed in detail on the claim form or provided as an attachment (i.e. a copy of the supply invoice).

If billing for an unlisted drug, physician/provider must include a detailed description, the dosage given and the NDC number for the drug.

If a claim is filed using an unlisted code and a valid code is available, unless specifically allowed by physician/provider contract, Plan will deny the service or supply and the claim for that service or supply will need to be re-filed by the physician or provider.

VI. CLAIMS FILING DEADLINES

Initial Claim Filing:
The Plan contract/agreement states that encounters/claims must be submitted within thirty (30) days of rendering authorized Health Care Services to a Member, or sooner if required by Doctors HealthCare Plans, Inc. or by laws, rules or regulations applicable to Plan. Specialty Provider shall remit encounter data and bill, but only if applicable, for such authorized Health Care Services rendered to the Member by submitting a Clean Claim to Plan. In the event that Specialty Provider is unable to submit a Clean Claim within the time specified because of circumstances beyond Specialty Provider’s control, the time for submission of such Clean Claim may be extended by Plan in its sole discretion pursuant to timely notice from Specialty Provider to Plan for a period not to exceed three (3) months or ninety (90) days from the date of service. Claims not received by Plan within ninety (90) calendar days will be denied and are to be considered waived by the physician. Participating providers may not balance bill members for benefits or services deemed waived as a result of the untimely filing of claims.

Billing for Obstetrical services should occur after the date of delivery using the appropriate CPT codes and within ninety (90) calendar days of the date of delivery.
Hospitals should provide current insurance information to hospital-based physicians when available to allow those physicians to file claims to Plan in a timely manner.

**Initial Claim Filing When There is Another Insurance:**
If the member has other insurance and that insurance is the primary payer, the claim must meet the following criteria:

It must be filed with Plan within ninety (90) calendar days of the date on the primary payer’s Explanation of Benefits (EOB) or Remittance Advice (RA).

A copy of the primary payer’s EOB or the primary payer’s paid amount, showing the amount paid by that carrier, must be submitted with any claim filed with Plan. Plan requires the provider to adhere to the primary payer’s criteria (e.g. filing deadlines).

**NOTE:** Plan’s payment as a secondary payer will not exceed the amount specified according to contract, less the primary payer’s payment amount.

**Balance Billing:**
Plan contracted providers are not permitted to balance bill our members. Providers who continually bill members will be issued a written warning by the Plan. Balance billing Medicare Advantage members is in violation of State Statute 641.315 (2 & 3) and may result in termination of the provider’s contract.

**Claims Adjustments:** Providers may call to obtain claim status for up to three claims at a time during regular business hours. To better serve your needs, it is recommended claim status be obtained at least fourteen (14) business days after the submission or mailing of your claim.

**VII. CLAIM DISPUTES**

A claims dispute is considered any request by a Participating provider for review of the payment determination made by the Plan as it pertains to a paid or denied claim for which the Member has no liability. It is important to note that participating providers may not hold a Member of the Plan financially liable if such dispute is not resolved in the provider’s favor. Participating providers may present claims disputes for review within one hundred twenty (120) calendar days from the date of the corresponding Remittance Advice. Providers must submit the Claim Dispute Form to the following address:

Doctors HealthCare Plans, Inc.
Attn: Provider Inquiry Unit
2020 Ponce de Leon Blvd., PH 1
Coral Gables, FL 33134

You may download a copy of the Claim Dispute Form through the Plan’s Web Site at: [www.doctorshcp.com](http://www.doctorshcp.com). All information on the form must be completed to the extent required. Supporting documentation must include the Remittance Advice; additionally, you may submit medical records, progress reports or other information deemed necessary. Incomplete submissions will be returned to sender and will not be processed. Claim Disputes filed past one hundred and twenty (120) days from the date on the corresponding Remittance Advice will be considered as a late filing and will not be processed.

The Claim Dispute is reviewed by the Provider Inquiry Unit within 60 days from the receipt date. The results of the review will be communicated to the provider via a Resolution Form, and sent to the provider via fax or email. If the Plan reverses the denied claim; the services will be paid within sixty (60) calendar days after the date of resolution.
Note for Non-Participating providers: A Non-Participating provider is permitted to file a standard appeal only if the non-participating provider completes a waiver of liability form, which states that the Non-Participating provider will not bill the Plan’s Member regardless of the outcome of the appeal. The Plan will not undertake a request for reconsideration of a denied claim from a Non-Participating provider if a waiver of liability form is not submitted. The time frame for acting on an appeal request commences when the appeal and the properly executed waiver of liability form are received. If the Plan receives an appeal, but no waiver of liability form; the Plan will forward the case to the independent review entity with a request for dismissal within thirty (30) calendar days after the receipt day. If the Plan reverses the denied claim; the services will be paid within sixty (60) calendar days after the resolution date.

Note for Delegated Entities: In the case of services being administered by a Delegated Entity, claim disputes must be submitted directly to the Delegated Entity and reviewed within the Delegated Entity’s claim review process. For additional details, please refer to the Delegated Entity you are affiliated to and review your participating provider agreement with that Delegated Entity.

Note regarding Medicare Beneficiaries enrolled in the QMB Program: DHCP network providers are prohibited from collecting Medicare Part A and Part B coinsurance, co-payments, and deductibles from those enrolled in the Qualified Medicare Beneficiary (QMB) Program, a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B cost-sharing. This notice will appear in the remittance advices for Medicare Beneficiaries enrolled in the QMB Program.
OVERVIEW
The purpose of a Quality Improvement Program, and related Quality Workplan, is to ensure that Doctors HealthCare Plans, Inc. has the necessary infrastructure in place to coordinate an excellent level of care in a fiscally responsible manner, provide responsive customer and provider services, promote quality, performance, and operational efficiencies on an ongoing basis.

Doctors HealthCare Plans, Inc. is committed to ensuring the execution and implementation of a Quality Improvement Program that is accountable to report measurable data in clinical areas and non-clinical areas including effectiveness of care, member perception of care, and use of services; access to and availability of services, appeals and grievances, and organizational characteristics. The organization’s Quality Improvement Program (QIP) provides
the framework and a robust structure within which the Plan is able to develop and implement quality improvement projects, to develop and implement chronic care improvement programs, to measure performance using regional and national standard measures required by CMS, and in doing so, enlists the cooperation of participating network physicians and other providers in selecting and prioritizing quality improvement projects, developing indicators, analyzing performance, identifying and proposing solutions to problems and aiding in communication of program activities with the Plan’s members, and participating providers and stakeholders.

The QI Program promotes the objective evaluation of the Plan as it operates to drive quality health care. The QIP provides a systematic measurement, monitoring, and evaluation of services, and implements quality improvement activities based upon findings.

The QI Program is established, directed and approved by the Board of Directors. The Chief Medical Officer or designee is designated as the executor of the QI Program and has the authority and day to day responsibility for the overall operation of the Program. The Chief Medical Officer or designee is responsible for all clinical aspects of the Program and works closely with the Medical Management team to carry out those duties. All senior and department leadership are responsible for implementing the Program throughout the organization. The Plan committee structure has an important role in implementing the Program; the Credentialing, Medical Management, and Peer Review Committees include network providers in their membership. See Section Three for more information on committees.

The Program is designed to comply with regulatory and applicable accreditation guidelines. It is evaluated and updated on an annual basis. The final QIP is reviewed and approved by the DHCP Board of Directors.

The overall goal of the QIP is to achieve quality care and services for members through the development, implementation and ongoing improvement of organizational systems.

Consistent with its emphasis on quality, our Plan maintains the QIP with goals to:

• Promote physical and mental/behavioral health for Plan members;
• Promote evidence-based medicine;
• Promote healthy lifestyles, risk identification, and early intervention;
• Promote active involvement by the member in health care planning and shared decision-making;
• Promote and coordinate efficient and effective utilization of resources;
• Facilitate timely access and availability to care and services;
• Facilitate communication regarding performance improvement initiatives;
• Promote consumer safety;

1. SCOPE

As a comprehensive Quality Improvement Program, it addresses the needs of members, providers, and other external consumers as well as internal departments and operational efficiencies. It integrates industry performance standards and data from within the organization’s own operational experience. The Program addresses components of health care management including the anticipation, identification, measurement, monitoring, evaluation of health care needs and system performance, and the design and implementation of effective improvement strategies.

Components of the Plan QIP include but are not limited to:

• Access and availability
• Completion of Health Risk Assessments for all Special Needs Program (SNP) enrollees within (90) days of enrollment with the Plan
• Case/Care management
• Clinical quality improvement initiatives, including quality improvement projects
• Credentialing and re-credentialing
• Delegation oversight
• Disease management
• Grievances and appeals
• Health education and Wellness Promotion
• Member rights and responsibilities, including advance directives
• Member and provider communication
• Participation with Member and Provider satisfaction surveys
• Medical record documentation practices
• Peer review
• Preventive health guidelines/clinical practice guidelines
• Risk management/Adverse Incident Reporting System
• Utilization management

Physicians and other providers play an integral role in the implementation of the QI program and are expected to understand and acknowledge the Plan’s QI Program, policies and procedures. A copy of the Plan Quality Management and Improvement Program and associated policies and procedures is made available to providers upon request.

II. MEDICAL RECORDS RECORDING AND MAINTENANCE CRITERIA

Plan requires providers to maintain complete and accurate medical records for all Plan members that:

• Document the chronology of member care.
• Serve as a basis for planning member care and for continuity in the evaluation of member’s condition and treatment.
• Document evidence of the course of a member’s medical evaluation, treatment, and change in condition.
• Document communication between the responsible provider and other health professionals that contribute to the member’s care.
• Serve to validate risk adjustment data as required by CMS.

Periodic reviews of the medical records maintained by participating providers are conducted to assess compliance with documentation standards and procedures regarding medical records management and privacy/confidentiality of member’s medical information.
Providers are expected to comply with the following medical record documentation standards:

- Personal/biographical data including member name, identification number, gender, date of birth, phone number, address, and legal guardianship, when indicated, are recorded in the record.
- Each page in the record contains the member’s identification; name and/or ID number.
- Documented assessment of communication needs, need for language translation, e.g. hearing impaired.
- Documentation of primary language.
- All entries are dated.
- All entries are signed; author identification by profession is included e.g. MD, DO, RN, MA, etc.
- The record is legible to individuals other than the individual making the entry.
- Medication allergies and adverse reactions are prominently and uniformly noted in the record. If the member has no known allergies or history of adverse reactions, including medications, over the counter medicines, herbs, food, and other substances (such as latex) this is noted in the record e.g. no known allergies - NKA.
- The medical history, to include current medications (prescription, OTC, herbals), is documented.
- Documentation of tobacco, alcohol and drug use and/or abuse.
- A problem list to include significant medical and surgical history is maintained.
- Current immunization record or age appropriate immunization status is documented.
- Patient’s chief complaint and objective findings are documented.
- Diagnoses or clinical impressions consistent with findings are documented.
- A plan of care, to include prescribed medications, is documented.
- Unresolved problems from previous visits are addressed.
- Member education regarding risk factors and the plan of care is documented.
- Documented evidence that ordered consultations and diagnostic testing were accomplished and results reviewed.
- Information regarding emergency department visits and hospitalizations is documented.
- Evidence of age appropriate preventive health screening and education.
- The record contains documentation of whether or not the individual has received written information or executed an advance directive.

Additional medical record requirements include:

- All entries are neat, legible, complete, clear, and concise.
- Entries are dated and recorded in a timely manner.
- Records are not altered, falsified or destroyed.
- Addendum notes are dated and timed to accurately reflect the time the entry is made.
- Incorrect entries are corrected by:
  - Drawing a single line through the error.
  - Do not obscure initial entry.
  - Dating and initialing each correction.
  - Making no additions or corrections to a medical record entry if a medical chart has been provided to outside parties for possible litigation.
• All triage calls and telephone messages are documented.
• Medical records are secured in a safe place to promote confidentiality of member information.
• Medical records and information are maintained in a confidential manner. Minor members’ consultations, examinations, and treatment for sexually transmittable diseases are maintained confidential.

ADVANCE DIRECTIVES
Plan provides written information to all members at the time of enrollment concerning their rights under Florida law to make decisions concerning the right to accept or refuse medical or surgical treatment and the right to formulate, at the member’s option, advance directives. Providers are asked to provide members with information regarding advance directives. The member’s medical record must indicate whether or not the individual has executed an advance directive, and a copy of such advance directive must be retained as part of the medical record of the member. Member education regarding advance directives should be documented in the medical record. Members may also call the Doctors HealthCare Plans, Inc’s. Member Services Department to request an advanced directive form.

III. ACCESS STANDARDS

Plan maintains and monitors a fully contracted provider network in sufficient numbers and disciplines to provide adequate access to and availability of covered services. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers. Access and availability standards have been established and are monitored within the organization. There are standards directly related to provider practices and to which providers are required to comply. Compliance is monitored with results reported through the committee structure.

Standards Regarding Appointment Access and Availability:

1. Access to physician services 24 hours per day/7 days per week.
2. Urgent Care, non-emergent, appointments available within 24 hours.
3. Non-urgent care appointments available within 7 calendar days.
4. Routine and preventive care PCP appointments available within 30 calendar days.
5. Regular specialty referral appointments within thirty (30) calendar days.
6. Practice capacity shall not exceed: One (1) physician FTE to 2500 Medicare members.
7. An allied health care professional (PA or ARNP) counts as 0.5 physician FTE for Medicare members.
8. Members with scheduled appointments shall be seen within thirty minutes of the scheduled appointment time. Members shall be informed of unavoidable delays and provided with alternatives.
9. Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.
IV. MEMBER HEALTH EDUCATION AND WELLNESS PROMOTION

Providers are expected to provide health education to Plan members on topics that are reflective of the demographics, local culture and health status of the population served. Members with specific health education needs should be provided education specific to those needs and access to health education resources, programs or services appropriate for their needs.

Member health literacy relates effective provider-member communication and health education. Plan encourages all providers to assess communication barriers and use appropriate language and reading level materials to facilitate quality health education.

Plan encourages providers to participate in initiatives to educate Plan members by submitting articles for publication in member newsletters. If you have a topic to suggest or an article to submit contact the Member Services Department or your Provider Relations representative.

V. PREVENTIVE HEALTH SERVICES

Plan promotes preventive health education and screening to support member health and quality of life independent of age. Evidenced-based, age-specific, preventive health guidelines are adopted by the health plan through selection and approval by the Medical Management Committee. Information regarding guidelines is disseminated to providers. Sources for preventive health guidelines include, but are not limited to, the U.S. Preventive Services Task Force (USPSTF), Center for Disease Control (CDC) Recommendations for Adult Immunizations, HEDIS Effectiveness of Care Measures, and the American Diabetes Association, Standard of Medical Care in Diabetes.

Member screening rates and plan performance are monitored through HEDIS access and effectiveness of care measures, quality improvement projects, and periodic review of medical record documentation.

VI. TARGETED DISEASE MANAGEMENT PROGRAMS

Plan is committed to continually provide quality health care and services to members through the development of Disease Management Programs that have the potential of facilitating dramatic improvement in the health, productivity, satisfaction and quality of life of members with chronic diseases. The goals of Plan Disease Management Programs are to:

- Reduce unnecessary disparities in the delivery of health care services to members with chronic or acute diseases through the adaptation and implementation of evidenced-based clinical treatment and practice guidelines.
- Improve the health and quality of life of Plan members with acute or chronic conditions through intervention programs that identify, inform, and educate members, providers and other partners in health care.
- Measure and track the improvements yielded by the intervention programs through clinical and outcome studies based on reliable tested information and methodology.
The Disease Management Programs consist of integrated systems of measurements and interventions that seek to identify, assess and address issues that compromise the efficient and effective delivery of health care services. Each Disease Management Program involves active participation from the member, the member’s family (if available), and health care providers (physicians and case manager) to further maximize the effectiveness of the interventions. The goal is to empower individual members with chronic conditions to work collaboratively, in a partnership relationship, with primary care physicians, specialists, case managers, and their family members to modify lifestyle behaviors and take control of their condition and exhibit compliance with recommended treatment regimens.

Plan offers targeted disease management for the following conditions:

- Diabetes
- Chronic Heart Failure (CHF)

Each of the targeted Disease Management Programs share the following common components and corresponding component specific objectives:

1. Comprehensive Assessment and Risk Stratification designed to:
   - Fully profile the health, mental health and functional status of the member.
   - Identify lifestyle risk factors associated with the member’s condition.
   - Insure that members, based on determined risk factors and co-morbid conditions, are administered appropriate treatment regimens.

2. Member Information/Education intended to:
   - Increase member’s level of understanding of their chronic condition and the potential consequences of lifestyle behaviors on the staging of the condition and the development of other serious co-morbid chronic conditions.
   - Empower members with the skills and motivations to alter negative lifestyle behaviors.
   - Enlist the member as a partner in the care and management process.

3. Provider Education designed to:
   - Insure that providers are aware of and utilize current practice guidelines for the treatment and management of targeted conditions.
   - Insure that providers keep pace with new and effective treatment protocols.
   - Enlist PCPs and Specialists as partners in the overall treatment and management process, to include modifications in the member’s lifestyle behaviors.

4. Member Case Management and Planning directed at:
   - Insuring coordination of appropriate and effective care and treatment.
   - Developing individualized care plans that correspond to the unique needs of the member.
   - Reinforcing and motivating members toward positive lifestyle behaviors.
   - Serving as a liaison for the member in the treatment and management process.
   - Influencing appropriate treatment and medication compliance.

5. Medication/Treatment Compliance Surveillance designed to:
   - Monitor and enhance medication treatment compliance among members.
   - Monitor and evaluate medication treatment patterns among providers.
– Identify potential negative effects of medication treatment, to include drug-to-drug interactions, contraindications, and medication side effects.

6. Outcome Evaluation designed to determine the effectiveness of the targeted Disease Management Program relative to the following outcome measures:

1. Lifestyle health behaviors
2. Self-care management
3. Provider/member interactions
4. Medication and treatment compliance
5. Member quality of life
6. Use of evidence-based practice guidelines
7. Disease complications and co-morbid conditions
8. Emergency room visits
9. Hospital admissions and re-admissions

Potential member candidates for the Plan Disease Management Programs are identified by the PCP, family member, or the Utilization Management and Care Management Areas. Once identified, the member and his/her PCP are sent a letter stating that the member has agreed to participate in the disease management program offered by Plan which is derived from evidence based clinical practice guidelines and inviting PCP participation. Subsequent to the forwarding of the letter, a Plan case manager contacts the member to discuss interest in participation. If the member elects to participate, the member is sent information/educational materials on the full disease management program and a date and time are established for the comprehensive assessment and risk stratification.

The disease case manager, member, PCP, and family members (if available), establish a care plan. The case manager communicates with the member and the PCP to identify progress toward the management of the condition, problems regarding treatment compliance and adherence, and provide support and reassurance.

VII. QUALITY IMPROVEMENT INITIATIVES, STUDIES AND PROJECTS

Quality improvement initiatives and activities are both clinical and non-clinical and may involve quality improvement projects, focus studies, monitoring operational indicators, and consumer input.

Clinical improvement initiatives focus on the improvement of different aspects of clinical care and services. Quality improvement activities (QIAs) are designed and conducted in accordance with regulatory requirements and nationally recognized accreditation standards. QIAs that are not corrected immediately may be transferred into a Quality Improvement Project – an ongoing process to eliminate or reduce a problem and/or increase compliance with an activity or effort. Quality projects measure and analyze health plan performance using objective, clearly defined indicators; they are evidence-based, and capable of measuring outcomes or valid proxies of outcomes such as health or functional status, member satisfaction, and/or use of preventive services demonstrated to improve health outcomes. Valid techniques are used to measure baseline data, conduct periodic re-measurement and assess performance and effectiveness of specific interventions. Performance improvement is measured against pre-established, quantifiable goals.
HEDIS data measures performance on different dimensions of care and services and allows for comparisons with other Medicare Advantage plans within the State and nationally. Audited, reliable data is used for many initiatives within the organization. Much of the data collected for HEDIS reporting, as well as other quality initiatives, are obtained through administrative data such as claims, encounter and pharmacy data. Some measures require administrative data and medical record review. During the process of medical record review and abstraction, Plan relies on the cooperation of network providers for timely access to the records.

Providers should always strive to complete HEDIS measure requirements as soon as possible for each plan member. As our focus is centered on healthy lifestyles, fulfilling these requirements is essential for members to meet their individual health goals. Together we help our members by recognizing and removing barriers that may keep them from satisfying every HEDIS measure. The provider is in the best position to provide counsel while performing exams, and ordering all of the lab tests and diagnostics necessary to reach the highest level of quality health care delivery.

DHCP has clinical QIAs in place at all times focusing on the prevention of acute or chronic health conditions and consumer safety. Our Quality Improvement team will reach out to provide you with strategies and helpful business practices. Additionally, operational improvement initiatives will be offered involving the monitoring of key operational indicators. These provide focus on improving organizational processes and operational efficiencies.

**VIII. MEMBER SATISFACTION**

Member satisfaction is monitored with the intent of continuously improving processes and outcomes that affect members. Sources of satisfaction information include grievances and appeals and the CAHPS (Consumer Assessment of Healthcare Providers and Systems) satisfaction survey. Focused satisfaction surveys may also be conducted in areas such as Health Education and Wellness Promotion, satisfaction with the Disease Management Program, and other areas. Data is evaluated for outstanding performance and improvement opportunities. Improvement initiatives are implemented to reverse adverse trends, improve processes, and sustain improved member satisfaction. Results of the satisfaction surveys are shared with members and providers.

**IX. PROVIDER SATISFACTION**

Provider satisfaction is very important to Plan and is monitored with the intent of continuously improving the processes and outcomes that affect providers. In addition to the routine interaction between Plan and network providers, sources of satisfaction information include grievances and appeals and an internal Provider Satisfaction Survey. Data is evaluated for outstanding performance and improvement opportunities. Improvement initiatives are implemented to reverse adverse trends, improve processes, and achieve and sustain high levels of provider satisfaction.

Plan encourages providers to participate in the survey process. Surveys are administered each calendar year and are distributed through a variety of ways. The survey form is accessible on the Plan website and can be submitted electronically. Results of the satisfaction survey are shared with members and providers.

**X. PEER REVIEW PROCESS**

Plan has a mechanism in place to investigate and take action to resolve quality of care issues and concerns to include the monitoring and trend analysis. The peer review process is evidence-based and involves participating network providers. All peer review activity is treated confidentially.
As part of the process which has been approved and is reviewed annually by the Medical Advisory Committee, providers could potentially be assigned points based on a system where points equate to a degree or gravity of a quality issue. A copy of the “Quality of Levels” and point assignments are available to any participating provider upon request.

Providers who are assigned quality of care points, with or without referral to the Peer Review Committee, are notified in writing of the investigation, assigned points and their significance, and the provider’s dispute rights with instructions on how to file a dispute.

The Peer Review Committee, with a membership that includes network providers, plays a key role in the process (see Section Three). Providers have the right to participate in the Peer Review Committee process; they may participate through the submission of written materials, and/or by participating in Committee meetings via teleconference or in person.

Providers have the right to dispute actions taken as a result of a quality of care investigation or professional competency or conduct. Providers are notified of decisions in writing to include dispute rights and instructions. Disputes must be filed in writing within fifteen (15) business days of receipt of the notification.

The dispute process offers two-levels of dispute. The first-level review panel is convened within twenty (20) business days of receipt of the dispute request and written notification of the decision is mailed within three (3) business days. Notification of a decision in favor of the provider will include an explanation of actions being taken to effectuate the decision. If the decision of the first-level review is not in favor of the provider, the provider is notified of the effective date, the right to consideration by a second-level panel, and the procedures and timeframes to request the additional review. A second-level review panel includes providers not involved in previous reviews and is convened within twenty (20) business days of the request. Notification of second-level reviews, mailed within three (3) days, include the decision, an explanation of actions being taken to effectuate the decision, and the effective date.

The exception to the procedures above is in the event of an emergency suspension of a provider participation status in the network; in this case the provider is notified immediately by phone, with written notification to follow and the convening of the Peer Review Committee for the first-level review is within five (5) business days of the suspension action.
OVERVIEW
The Medical and Case Management Programs are based upon nationally accepted accreditation standards and guidelines as defined by CMS regulations.

The Medical Management program focuses on:

- Providing access to culturally sensitive services that are medically necessary, appropriate, and are consistent with the member’s diagnosis and level of care required;
• Monitoring, tracking, and trending care provided to members to ascertain that quality health care is being provided;
• Reducing overall health care expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership to foster improved care and wellness;
• Facilitating communication and partnerships among members, families, providers, delegated entities, and the Plan in an effort to enhance cooperation and appropriate utilization of health care services;
• Identifying members with special needs, potential or high-risk disease states, high resource usage, or high cost diagnosis, and intervening to maximize appropriate utilization and delivery of appropriate health care through the efficient use of resources;
• Reviewing, revising, and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
• Enhancing the coordination and minimizing barriers in the delivery of behavioral health and medical health care services.

Medically necessary services are defined as services that include medical or allied care or services furnished or ordered to:

• Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
• Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member’s needs;
• Be consistent with the generally accepted professional medical standards in light of conditions at the time of treatment and not be experimental or investigational:
• Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available; and
• Be furnished in a manner not primarily intended for the convenience of the member, the member’s caretaker or the provider.

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

I. UTILIZATION MANAGEMENT DECISION MAKING

Plan uses review criteria that is nationally recognized and based on sound scientific, medical evidence and current clinical principles and practices. The appropriate use of criteria is incorporated in all phases of the utilization decision making process by licensed staff and the Medical Director(s). This assist us in administering health benefits and determining coverage and are used as a reference resource, screening criteria, and guideline in making decisions regarding medically necessary services and not as a substitute for professional judgment.

The following criteria are utilized by the UM department along with State and Federal Regulation, but not limited to:

• Milliman Care Guidelines (MCG)
• National Coverage Determinations (NCD)
• Local Coverage Determinations (LCD)
• Coverage Issues Manual (CIM), CMS online: http://cms.hhs.gov/
• Member’s Benefit Coverage as described in the Plan Evidence of Coverage
• Regulatory and/or governmental bodies, e.g., FDA, NIH, PubMed
• CMS Designated Medical Compendia
• Federal and State mandates

The Medical Director evaluates all cases that do not meet medical necessity and will make the appropriate utilization decision based on review of the clinical information provided in conjunction with discussion with the ordering or attending physician.

The Medical Director is available to discuss the decision in the event that a practitioner/provider questions the medical necessity/appropriateness of a modified or denial determination made by the Medical Director. The utilization criteria used in the decision process is available to the requesting physician upon request. Only a Plan Medical Director may issue a denial for covered services.

Plan does not reward practitioners, staff or other individuals for denying coverage or services. Plan does not provide financial incentives to employees, including Utilization Management staff, for decisions that establish barriers to care or decisions that support under-utilization. Plan employees sign an attestation to this as a requirement of employment.

II. MEDICAL MANAGEMENT (MM) PROCESS

A copy of the Request for Prior Authorization of Benefits/Services is provided to you with this manual and can be requested electronically through Provider Relations, under the Provider Section of Plan website www.doctorshcp.com along with the Plan Quick Reference Guide.

III. NOTIFICATIONS

Notifications are communicated to Plan within 24 hours of any hospital admission. Facilities must notify Plan of members admitted for an observation, inpatient admission, and/or if an observation rolls into an inpatient stay to expedite discharge planning, case management, and the claims process and to ensure timely claims reimbursement.

IV. PRIOR AUTHORIZATIONS

Precertification or Prior authorization allows for coordinated, efficient use of Participating Network Providers for covered health care services and ensures that members receive the most appropriate level of care in the appropriate clinical setting.

Prior authorization is required in advance of rendering a service that may or may not require a medical review. Elective admissions, SNF, LTAC, or inpatient rehabilitation admissions and other outpatient services or course of treatment in a hospital or other facility as designated by Plan require prior authorization. Plan will make determinations based on the clinical information obtained at the time of the review. Plan may request additional documentation or medical records to assist in the determination process.
A Prior Authorization Form should be filled out completely and legibly to be processed in a timely manner. A current, operating fax number or secure e-mail must be included on the form. Once Plan agrees that the treatment is necessary and is a covered benefit, an authorization number, which is necessary for payment, will be provided electronically or via fax. Prior authorization requests should include:

- Member demographic information
- Physician/Provider demographic information, including requesting and referred to providers
- Requested service/procedure, including specific CPT/HCPCS codes
- Member diagnosis (ICD code and description)
- Location of where the service will be performed
- Clinical indication necessitating service or request
- Pertinent clinical and laboratory information supporting the medical necessity of the request

Providers may request an “Expedited” authorization for services that are emergent/urgent in nature by indicating this on the pre-cert request and stating the reason for the “Expedited” request. Plan will make a determination within 24-72 hours for urgent requests once all the information is obtained. Please have the member’s name, ID number, diagnosis, and requested service available when calling and the requests will be handled expeditiously.

Expedited is defined as, “a service, that if delayed, would detrimentally affect a member’s health or functional capabilities if not performed immediately.” This does not include requests that the office failed to submit in a timely fashion.

Contact your Provider Representative for access and training on how to submit requests to Plan.

NOTE: Please be advised that Plan may have delegated arrangements with certain provider groups, for which there may be a different process, form or steps to take other than outlined here for Plan in cases of prior authorization requests or claims submissions. Authorizations for services that are covered under a capitated provider/network/delegate should be submitted directly to the provider/network/delegate.

V. SERVICES NOT REQUIRING AUTHORIZATION BY PLAN

Doctors HealthCare Plans, Inc. is financially responsible for emergent or urgent needed services. No materials furnished to enrollees may contain instructions to seek prior authorization for emergent or urgent needed services and enrollees must be informed of their right to call 911. No materials furnished to providers, including contracts, may contain instructions to providers to seek prior authorization before the enrollee has been stabilized.

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; or
- Serious dysfunction of any bodily organ or part
Emergency services means covered inpatient and outpatient services that are:

(A) Furnished by a provider qualified to furnish emergency services; and
(B) Needed to evaluate or stabilize an emergency medical condition

Urgently needed services means covered services that are not emergency services as defined in this section, provided when an enrollee is temporarily absent from the Plan’s service area when the services are medically necessary and immediately required:

(A) As a result of an unforeseen illness, injury, or condition; and
(B) It was not reasonable given the circumstances to obtain the services through the organization offering the MA plan.

The Plan is financially responsible for emergency services and urgently needed services:

- Regardless of whether services are obtained within or outside the plan’s authorized service area and/or network;
- Regardless of whether there is prior authorization for the services;
- If the emergency situation is in accordance with a prudent layperson’s definition of “emergency medical condition,” regardless of the final medical diagnosis; and
- Whenever a plan provider — a provider with whom the Plan has a written contract to furnish plan covered services to its enrollees — or other plan representative instructs an enrollee to seek emergency services within or outside the plan.

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the Plan.

Post-stabilization care services mean covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition.

The Plan is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, if the attending physician is treating a fracture, the plan is not responsible for any costs connected with a biopsy of skin lesions performed while treating the fracture.

Ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary’s health do not require prior authorization.

Doctors HealthCare Plans, Inc. has determined that many routine procedures and diagnostic tests may be performed without medical review to facilitate timely and effective treatment of members. Certain diagnostic tests and procedures are considered, by Plan, to be a routine part of an office visit, such as cystoscopy, EKG, and plain film x-rays.

VI. CONCURRENT REVIEW

Concurrent review activities involve the evaluation of a continued hospital, skilled nursing, or acute rehabilitation stay for medical appropriateness utilizing proper criteria. This review is performed telephonically or on-site via chart review by Utilization Review (UR) Nurses using information obtained from the attending physician, hospital staff, Case Management staff or hospital clinical staff involved in the member’s care. Concurrent review is conducted within 24 hours of or on the next business day following notification of the admission whenever possible. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity of the condition, treatment
plan and discharge planning activity. Assessment is derived by applying MCG criteria in order to assure the appropriateness of the admission and to provide continued stay authorization using Plan criteria including:

- Services provided in a timely and efficient manner;
- Assuring established standards of quality care are met;
- Implementing timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Implementing effective discharge planning; and
- Identification of cases appropriate for Complex Case Management

The UR Nurse, under the direction of the Plan Medical Director, completes an initial assessment of the reported clinical findings and takes into consideration the individual needs of the member. MCG criterion is applied to determine appropriateness of the admission and to provide continued stay authorization.

To ensure the request is completed in a timely manner, providers must submit relevant clinical information along with the request for authorization to the UR Nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

VII. DISCHARGE PLANNING

Discharge planning is a collaborative and cooperative effort among the attending physician, hospital discharge planner, Plan UR Nurse, member, ancillary providers, and community resources in the coordination of care and services.

Discharge planning begins on admission and is designed for early identification of medical, behavioral, and/or social issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost effective quality driven treatment intervention for post-hospital care at the earliest point in the admission in support of appropriate utilization.

VIII. RETROSPECTIVE AUTHORIZATIONS FOR HOSPITAL ADMISSIONS

Retrospective authorization requests are considered for review only if they are submitted to the Medical Management Department within three days from the date of service.

A request for a retrospective authorization is reviewed based on the medical information made available by the provider at the time medical care was provided.

IX. STANDARD, EXPEDITED AND EXTENSION OF AN ORGANIZATION DETERMINATION

Organization Determination is defined as any determination made by the Plan with respect to any of the following:

- Coverage for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
• Coverage for any other health services furnished by a provider other than the Plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Plan;
• The Plan’s refusal to cover services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Plan;
• Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
• Failure of the Plan to approve, furnish, arrange for, or provide coverage for healthcare services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Requests submitted for prior authorization determinations should be requested ten (10) days prior to the date of service, when possible. If required for the requested service, fax pertinent medical records to support the need for the service and/or procedure requested along with a completed Prior Authorization Request Form.

X. STANDARD ORGANIZATION DETERMINATION (APPROVAL OR DENIAL)

Authorization responses will be sent to the providers’ contact information on record with the Plan. Plan has up to fourteen (14) calendar days from receipt of request to determine whether a member’s request for non-urgent services is a medically appropriate and covered service. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider requests an extension or if Plan justifies to CMS a need for additional information and the extension is in the member’s best interest.

XI. EXPEDITED ORGANIZATION DETERMINATION

An enrollee, or any physician (regardless of whether the physician is affiliated with the Plan), may request to expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee’s life, health, or ability to regain maximum function in serious jeopardy. When asking for an expedited organization determination, the enrollee or a physician must submit either an oral or written request directly to the Plan. If the Plan decides to expedite the request, it must render a decision as expeditiously as the enrollee’s health condition might require, but no later than 72 hours after receiving the enrollee’s request.

If the provider indicates on the Prior Authorization Request Form, or Plan determines, that following the standard timeframe could place the member’s life, health or ability to regain maximum functionality in serious jeopardy, Plan will make an expedited authorization determination and provide notice within 72 hours. Plan may extend the 72-hour time period up to fourteen (14) calendar days if the member or the provider requests an extension, or if Plan justifies to CMS a need for additional information. Providers and/or members may request an expedited organization determination by telephone or fax.
XII. MEDICARE QIO REVIEW PROCESS FOR INPATIENT AND SNF/HHA/CORF TERMINATIONS

Providers should ensure delivery of written notification two days in advance of services ending for Skilled Nursing Facilities, Home Health Agencies, or Outpatient Rehabilitation Facilities. In the event that a member appeals the termination of services, Plan will work collaboratively with the provider to obtain medical information necessary to review these cases within the allotted time frame.

XIII. EMERGENCY SERVICES

Plan covers, without an authorization, emergency services necessary to screen and stabilize members based on the definition in F.S. 409.901 (9). Plan provides coverage for inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the “prudent layperson” standard—A Standard for determining an emergency as a condition a prudent layperson who possesses an average knowledge of health and medicine expects. Plan does not impose restrictions on coverage of emergency medical services that are more restrictive than those permitted by the “prudent layperson” standard. Plan does not deny payment based on a member’s failure to notify Plan in advance of seeking treatment or within a certain period of time after the care was provided.

Plan provides for emergency services when necessary care is not available within the provider network or is needed outside of the service area, the “prudent layperson” standard applies. Authorization is not required for emergency services based on the “prudent layperson” standard.

Services provided by physicians in the ER to treat or stabilize the member are not subject to utilization review.

Prior authorization is not required for ambulance services dispatched through 911 or its local equivalent as may be provided for transportation to the ER.

XIV. SECOND MEDICAL OPINION

All Plan members have the right to request a second opinion in-network, unless unavailable, from their PCP or Specialist. Plan Member Service Representatives can provide assistance to the member in obtaining the consultation service, if necessary. Second Medical Opinion is defined as a consultation by a physician other than the Member’s primary care physician, whose specialty is appropriate to the need, and whose services are obtained when the Member disputes the appropriateness or necessity of a surgical procedure, or is subject to a serious injury or illness, including failure to respond to the current treatment plan. 59A-12.002(11), F.A.C.

A member may request and is entitled to a second medical opinion when:

a. The Member believes that s/he is not responding to the current treatment plan in a satisfactory manner following a reasonable lapse of time for the condition being treated.

b. The Member disagrees with the opinion of their treating physician regarding the reasonableness or necessity of a surgical procedure or the treatment plan for a serious injury or illness.

c. The Member will need surgery or is diagnosed with a major non-surgical condition and/or requires diagnostic/therapeutic procedure(s).
XV. OUT OF NETWORK

All out of network services require prior authorization and must be submitted to the Plan on the Request for Prior Authorization Form. Participating Providers may request a copy of the form from Provider Relations or may download a PDF copy from the DHCP website www.doctorshcp.com.

In the event that a non-participating provider treats a Plan member for non-emergent services and has failed to obtain the proper authorization, results in failure to inform the member, with written consent obtained prior to treatment, shall result in the provider’s responsibility and financial liability for such services.

XVI. CARE TRANSITION/COORDINATION OF CARE

The PCP is the member’s “medical home” and is responsible for the coordination of care and services for the member. All members are encouraged to see their selected PCP to assist in the management and direction of care.

Plan in collaboration with the PCP makes a special effort to manage Transitions for its members and to coordinate care for members who move from one Care Setting to another. Plan member benefits are examined and members are assisted in obtaining these benefits so that members feel as if they are seamlessly transitioned from one setting to another.

Plan facilitates safe transitions for its members by:

- Identifying planned transitions
- Communicating with the member or responsible party about the transition process
- Communicating with the member or responsible party about changes to the member’s health status and care plan
- Assigning a case manager to support the member through all transitions of care
- Communicating with the member’s usual practitioner.
- Conducting analysis of the Plan performance on the above measures at least annually.

Plan identifies unplanned transitions by reviewing reports of admissions to hospitals and long-term care facilities within one business day of admission.

Plan minimizes unplanned transitions by:

- Analyzing data at least monthly to identify members at risk of transition
- Coordinating services for members at high risk of having a transition
- Educating members or responsible parties about transitions and how to prevent unplanned transitions.
- Analyzing rates of all member admissions to facilities and emergency room visits at least annually to identify areas for improvement.

XVII. TRANSPLANT MANAGEMENT

Plan offers transplant management with a Case Manager to ensure that information is available to providers and to facilitate all aspects of the transplant process. The Case Manager is available to interpret transplant benefits and to assist the member in choosing a facility from the Plan transplant network. Each transplant facility is chosen based
upon its level of expertise and standards of care using an established set of criteria. Transplant coverage includes pre-transplant, transplant, and post-discharge services and treatments of complications after transplantation. Plan members’ benefits are examined and members are assisted in obtaining these benefits.

**XVIII. CASE MANAGEMENT**

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual’s health needs, using communication and available resources to promote quality, cost effective outcomes. It is one component used to control, direct, and approve access to the services available to members in their benefit packages. Case Management emphasizes continuity of care for the members through the coordination of care among physicians and other providers. Case Management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting. Case Management helps members with multiple and/or complex conditions or who have experienced a critical event or diagnosis and need extensive resources, navigate through the system and access care.

- PCPs serve as the principal care manager and coordinator of care. Plan Case Management Team serves as support capacity to the PCP and assists in coordinating care actively linking the member to providers, medical services, residential, social and other support services where needed.
- All members that meet criteria for case management are enrolled in the program, however, the program is strictly optional and members may choose to enroll or dis-enroll at any time.
- Providers may request enrollment for their members who have complex or on-going health care needs into the case management program by calling Health Services.
- The Case Management team is comprised of specially qualified nurses who assess the Member’s risk factors and develop an individualized treatment plan in collaboration with the PCP, specialists, member/caregiver and members of the health care team. The care plan is based on a health needs assessment and identifies immediate, short-term and long-term goals, monitors outcomes and evaluates whether the goals remain appropriate and realistic, and what actions may be implemented to enhance positive outcomes.
- Plan has incorporated Case Management programs that manage members who have complex or ongoing health care needs, preventive health and lifestyle issues or coordination of care/care transition needs. Members may also be referred to our programs that are designed to educate the member on self-management of their chronic condition utilizing evidence based guidelines.
- Plan has adopted clinical practice guidelines that are based on valid and reliable clinical evidence from agencies such as the American Diabetes Association (ADA) for diabetic management. Plan utilizes The Case Management Society of America (CMSA) Standards of Practice as a guideline for case management practice.
OVERVIEW
The primary purpose of the Plan Member Services Department is to respond to inquiries and resolve any issues from Members. Member Services Representatives are available Monday through Sunday 8:00 a.m. to 8:00 p.m. (Eastern Standard Time) 365 days a year, Speech and hearing-impaired Members may use the TTY/TDD line to access our Member Services Department at any time. Additionally, translation services are available as needed.

I. IDENTIFYING A PLAN MEMBER

When a patient seeks medical attention from a Physician/Provider office, eligibility should always be determined BEFORE services are rendered.
There are four (4) ways to verify eligibility:

1. **Membership ID Card:** All Doctors HealthCare Plans’ members are issued an identification card that displays the following:
   - Member Identification Number
   - Member Name
   - Assigned Primary Care Physician
   - Any applicable office visit and prescription co-payments

2. **Provider Relations:**
   - Call local telephone number within Miami Dade County service area (305) 422-9300 and select Option 3 or you may call Member Services at (786) 460-3427 or (833) 342-7463, if outside the service area

3. **Monthly Eligibility List:** Plan Primary Care Physicians may receive a list of Members assigned to his/her panel on or before the 10th day of the month upon request.

4. **Online Access:** Participating Providers may access eligibility and claims status information through our Provider Portal or by calling Provider Relations directly at (305) 422-9300 Option 2. Pre-registration to access our Provider Portal is required; please contact Provider Relations for assistance with registration.

II. **MEMBER SERVICES ASSISTANCE**

Members should call the Member Services Department at (786) 460-3427 or toll free at (833) 342-7463 (DHCP4ME) for any reason, including:

- Verify Eligibility and Coverage (if Provider does not have access to the Provider Portal)
- Benefit Questions
- Co-payment Questions

III. **MEMBER SELECTION OF A PRIMARY CARE PHYSICIAN (PCP)**

When a Medicare Beneficiary completes an Enrollment Form for participation in Plan, s/he selects a Primary Care Physician (PCP) from the Plan Provider Directory. If the Physician/Provider selected is not accepting new members or has terminated his/her relationship with Plan, or if a beneficiary does not select a PCP, Plan assigns the Member a PCP.

Each Member is mailed a member ID card. Some Members may be effective prior to receiving their member ID cards. For Medicare members, a copy of their Enrollment Form or a temporary ID card is proof of eligibility. It is customary practice for the Physician/Provider to ask to see the member ID card before services are rendered. If the Member has not received an ID card, or the card is lost, please contact Member Services to verify eligibility or verify eligibility electronically.
IV. MEMBER TRANSFERS

The following guidelines apply to the transfer of a Plan member, upon his/her request, from one PCP to another:

- The Member’s decision to transfer should be strictly voluntary.
- The Member must not have been directly recruited by phone or in person by anyone involved with the PCP.
- The Member must not have been influenced to transfer due to improper/incorrect information or for medical reasons.
- Upon receipt of a Member’s Medical Release Form, the PCP office is required to send the member’s medical records to the new PCP.

Whenever these guidelines are not followed, Plan will review the transfer. A transfer will not be approved if any of the preceding guidelines are violated.

- If the change is requested before the 10th of the month, then the change will be retroactive to the first of the month in which the member called to request the change.
- If the change is requested after the 10th of the month, then the change will be effective the first day of the following month.

V. DISENROLLMENT

VOLUNTARY DISENROLLMENT OF MEMBERS

Plan members may voluntarily disenroll from Plan by:

- Contacting Medicare directly at 1 (800) Medicare or,
- By calling the Plan Member Services Department at (786) 460-3427 or toll free (833) 460-3427
- By submitting a written request directly to the Plan Enrollment Services Department by mail to the following address:
  Doctors HealthCare Plans, Inc.
  Enrollment Services Department
  2020 Ponce de Leon Blvd., PH 1
  Coral Gables, FL 33134

INVolUNTARY DISENROLLMENT OF MEMBERS

CMS allows Plan to disenroll members involuntarily from the health plan due to:

- Fraud
- Behavior that is unruly, abusive or uncooperative to the extent that continued membership seriously impairs Doctors HealthCare Plans, Inc’s. ability to arrange for or provide services to the member or other members.
  An individual can’t be considered disruptive if such behavior is related to the use medical services or compliance or lack thereof with medical care or treatment.

The plan must notify CMS and ask for permission to involuntary disenroll members for these reasons. In the case of disruptive behavior, the plan must provide supporting documentation. The plan must also provide the member with several notices and an opportunity to change his/her behavior. Each step in the process requires CMS permission. CMS must be satisfied that the member’s behavior is not due to the member’s use of, or lack of use of, medical
services, member’s choice of or refusal of treatment and that plan has made reasonable accommodations for problems due to member’s mental health/cognitive conditions.

Please report suspected fraud (e.g., misuse of ID card, theft of prescription drug pads, drug-seeking behavior) or disruptive behavior to Plan. Please note that disruptive behavior must meet the CMS definition. We will need documentation of the behavior as well as efforts made to accommodate the member.

VI. PROCEDURE FOR REQUESTING A DISCHARGE OF THE MEMBER FROM YOUR PANEL

A PCP requesting to “discharge” a Plan member from his/her panel must submit a written request to the Provider Relations Department for review and approval. Upon approval, the Provider Relations Department will forward the request to the Member Services Department to complete member PCP transfer. The provider must submit the following documents:

- Complete/detailed description of the Member’s behavior.
- Any extenuating circumstances.
- Summary of the case and reason for transfer.

Plan will review the information and appropriateness of the request. For example, providers should not request a discharge of a member due to the member’s utilization of services or in retaliation against members who filed a grievance about the provider. Providers must demonstrate efforts to work with members who are non-compliant with treatment and the reasons for the non-compliance. If Plan approves the request, Plan will help the member select a new PCP. If transition of care is needed, the Utilization Management Department will also assist with the transition.

Please contact Member Services Department or Provider Relations Department for any issues or concerns you may have. You may also contact the Member Services Department to receive a faxed copy of the Transfer Request Form.
Doctors HealthCare Plans strongly endorses the Rights and Responsibilities of our members as supported by State and Federal laws. In joining the Plan, our Members become our partners as well as our family of health care professionals. The establishment of this partnership is an important element in satisfying our mission.

All member rights and responsibilities are to be acknowledged and honored by all staff and contracted Physicians/Providers. Primary Care Physician’s (PCPs) are urged to post our Plan’s Member Rights and Responsibilities in their office(s). Copies of these Rights and Responsibilities will be provided to Physicians/Providers from our Provider Relations Department. In addition, providers are expected to abide by the Florida Patient’s Bill of Rights and Responsibilities.
DOCTORS HEALTHCARE PLANS MEMBER RIGHTS & RESPONSIBILITIES

As a Doctors HealthCare Plans Member, you are afforded certain rights, responsibilities, and protections. The following summary of your Member Rights and Responsibilities is provided for your information. This does not alter or amend your health care coverage with Doctors HealthCare Plans, Inc. and we do encourage you to become familiar with them and welcome any questions or further assistance we may provide. These Member Rights and Responsibilities are available in your Evidence of Coverage (EOC), our website, and Provider Manual.

As a member of Doctors HealthCare Plans, Inc., you have the Right to:

- Be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your privacy.
- A prompt and reasonable response to questions and requests.
- Timely access to your covered services and drugs.
- Provisions for after-hours and emergency care.
- Select and change your provider (including your primary care).
- Know who is providing medical services and who is responsible for your care.
- Know what patient support services are available and receive information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
- Information about the plan, its network of providers (including credentials), and your covered services.
- Receive information regarding malpractice insurance of providers upon request.
- Know what rules and regulations apply to your conduct.
- Be given information concerning your diagnosis, planned course of treatment, alternatives, risks, and prognosis by your health care provider.
- Make decisions about your care and refuse any treatment, except as otherwise provided by law.
- Give Advance directives, which are instructions, about what is to be done if you are not able to make medical decisions for yourself.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
- Know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give consent or refusal to participate in such experimental research.
- Express grievances regarding any violation of your rights or being treated unfairly, as stated in Florida law, through the grievance procedure, of the health care provider or health care facility which served you and to the appropriate state licensing agency.
• To make complaints or ask us to reconsider any decisions we have made.
• Confidentiality of your health information.

As a member of Doctors HealthCare Plans, Inc., you have a Responsibility to:

• Provide your health care provider, to the best of your ability, accurate and complete information about present complaints, past illness, hospitalizations, medications and other matters concerning your health.
• Be responsible for reporting unexpected changes in your condition to your health care provider.
• Notify your health care provider whether you comprehend a contemplated course of action and what is expected of you.
• Follow the treatment plan recommended by your health care provider.
• Let your doctor and your other health care providers know that you are enrolled in our plan.
• Keep medical appointments and when unable to, notify the health care provider or facility.
• Provide a responsible adult to transport you home from a facility when you have a procedure performed and remain with you for 24 hours, if required by your provider.
• Be accountable for your actions when refusing treatment or not following the health care provider’s instructions.
• Assure that financial obligations for your health care are fulfilled as promptly as possible including co-payments, deductible, co-insurance amounts, non-covered services and benefits.
• Follow health care facility rules and regulations affecting patient care and conduct.
• Learn about your Plan and health care coverage through your Plan's member education material and Evidence of Coverage.
• Learn and adhere to the proper use of the Plan’s services and procedures for accessing medical treatment.
• Be respectful of all health care providers and staff, as well as other patients.
• Advise the Plan if you are leaving the Plan’s service area.
• Inform providers about living wills, medical power of attorney, or other directions called Advance Directives, affecting care.
• Call Member Services for help if you have questions or concerns.
Member Grievances and Appeals

Doctors HealthCare Plans, Inc. must provide written information to enrollees or their representatives about the grievance and appeal procedures that are available to them through the Plan at designated times. It must also establish and maintain procedures for standard and expedited organization determinations; standard and expedited appeals; and standard and expedited grievances. The Plan’s Medical Director has the responsibility of ensuring the clinical accuracy of organization determinations and reconsiderations involving medical necessity.

- The Grievance procedure - at initial enrollment, upon involuntary disenrollment initiated by the Plan, upon denial of an enrollee’s request for expedited review of an organization determination or appeal, upon an
The enrollee’s request, and annually thereafter;

- The Appeals procedure, including the right to an expedited review - at initial enrollment, upon notification of an adverse organization determination, upon notification of a service or coverage termination (e.g., hospital, CORF, HHA or SNF settings), and annually thereafter; and

- The Quality of care complaint process available under QIO process as described in §1154(a) (14) of the Social Security Act (the Act) - at initial enrollment, and annually thereafter.

All Plan members or their duly appointed representative have a right to file a complaint or an appeal/grievance. A complaint is defined as any expression of dissatisfaction to the Plan, provider, facility, or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or the Plan itself such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes the Plan’s refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process. For the purpose of this chapter and to provide guidance in the procedural course of handling the grievance and/or appeal process, the following definitions are offered.

**An Organization Determination** is defined as any determination made by the Plan with respect to:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;

- Payment for any other health services furnished by a provider other than the Plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;

- The Plan’s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Doctors HealthCare Plans, Inc.;

- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;

- Failure of the Plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

**A Grievance** is defined as any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which the Plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to the Plan, provider, or facility. An expedited grievance may also include a complaint that the Plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

**An Appeal** is considered to be any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These
procedures include reconsideration by the Plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

All Plan Participating Physicians/Providers are expected to be aware of and comply with Plan policies and procedures for Member Grievances and Appeals. As part of that responsibility Physicians/Providers, or their designees, are to recommend to members who voice a complaint that they have the right to process their complaint formally with the Plan.

I. THE GRIEVANCE AND APPEALS PROCESS

The Plan’s Member Services Department is responsible for receiving and resolving verbal member complaints (grievances). If the member is not satisfied with the resolution offered by Member Services, the member may file a written grievance with the Grievance and Appeals Department. The Member Services Department will provide assistance to members who need help in preparing a written appeal/grievance. Members must submit grievances within sixty (60) calendar days after the event that initiated the grievance:

- Matters involving a health plan provider, including complaints about the quality of services they receive.
- Delivery of care, including issues involving waiting time, physician behavior adequacy of facilities, or other similar member concerns.
- Enrollment/disenrollment issues.
- Any problems involving the delivery of Plan benefits package/materials.
- Disagreement with our decision to process a request for service or to continue a service under the standard fourteen (14) day timeframe rather than the expedited 72-hour timeframe.
- Disagreement with our decision to process an appeal for a service request under the thirty (30) calendar day timeframe rather than the expedited 72-hour timeframe.

Plan will take prompt, appropriate action, including a full investigation of the grievance, as expeditiously as the member’s case requires, based on the member’s health status, but no later than thirty (30) calendar days from the date Plan receives the grievance. The thirty (30) calendar day timeframe may be extended by up to fourteen (14) business days when a member requests the extension or if Plan justifies a need for additional information required in order to properly complete a review of the grievance. The Plan will provide timely notification to all concerned parties upon completion of the Plan’s investigation; Notification will be provided as expeditiously as the enrollee’s case requires based on the enrollee’s health status, but not later than thirty (30) calendar days from the date the grievance is filed with the Plan.

The Plan will respond to all Expedited Grievances relating to the Plan’s decision to extend the timeframe to make an organization determination or reconsideration or Plan refusal to grant a request for an expedited organization determination within twenty-four (24) hours.

The Plan Chief Medical Officer, Medical Director or designee is responsible for the triage of all formal quality of care grievances in order to determine if there is a quality of care issue involved. All grievances identified as a quality of care issue become the responsibility of the Medical Director. All quality related grievances are tracked by the Grievance and Appeals Department to ensure compliance with time guidelines set by statutes and/or regulatory agencies.
APPEALS PROCESS
Plan is committed to fair and accurate adjudication of appeals. Plan members, their authorized or appointed Representatives, may file a request for reconsideration (appeal) with Plan within sixty (60) calendar days from the date of receiving an adverse organization determination notice from the Plan. An adverse organization determination may be a denial of a claim payment request, a denial of a request for service, or a dispute about a copayment. If a party shows good cause, Plan may extend the time frame for filing a request for reconsideration. Plan will designate someone other than the person involved in the initial denial to review the appeal request. If the original denial was based on a lack of medical necessity, the appeal decision will be made by a physician with expertise in the field of medicine that is appropriate for the services at issue.

Plan will apply the prudent layperson standard in cases involving emergency services. For standard (non-expedited) appeals of service denials, Plan will make a decision as expeditiously as the member’s health condition requires, and in no event later than thirty (30) calendar days from the date Plan receives the appeal request. For claim payment denials or co-payment disputes, Plan will make its decision within sixty (60) calendar days. Plan may extend this timeframe by up to fourteen (14) business days if Plan needs additional information and the delay is in the member’s interest.

NOTE: There are special rules for “expedited appeals” where the standard timeframes for the appeals procedure would seriously jeopardize the member’s life, health or ability to regain maximum function.

Plan Grievance and Appeals Process, including where and how to file a grievance/appeal, is described in the member Evidence of Coverage and on the Plan website.
I. GENERAL INFORMATION

OVERVIEW
Doctors HealthCare Plans is committed to prevent, deter and detect potential non-compliance and Fraud, Waste & Abuse (FWA). To this end DHCP has implemented strong programs to fight non-compliance and FWA and is committed to maintaining high ethical standards and conducting business in compliance with applicable laws,
regulations, and requirements. Providers can either adopt DHCP’s Standard of Conduct, General Compliance Program, and FWA training or can have their own materially similar documents. Providers are responsible for educating employees and any downstream entities on compliance policies and standards of conduct whether they are DHCP’s adopted policies and standard of conduct or their own. Please note that hardcopies of DHCP Compliance materials may be requested at any time by contacting your assigned Provider Relations Representative. This is required upon 90 days of contracting and annually thereafter. Refer to website for information.

DEFINITION
Fraud, Waste & Abuse is defined as follows:

- **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

- **Waste** is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions, but by the misuse of resources.

- **Abuse** includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowing and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, amongst other factors.

REGULATIONS
According to The Office of Inspector General (OIG), the most important Federal laws that apply to health care providers in relation to FWA are:

- The False Claims Act (FCA)
- The Anti-Kickback Statute (AKS)
- The Physician Self-Referral Law (Stark law)
- The Exclusion Authorities
- The Civil Monetary Penalties Law (CMPL).

Government agencies, including the Department of Justice, the Department of Health & Human Services Office of Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS), are charged with enforcing these laws. Doctors HealthCare Plans has an obligation to investigate reports of fraud and report to the State, the CMS Medicare Integrity Contractor, and other government agencies.

EDUCATION & TRAINING
Doctors HealthCare Plans participating providers must provide FWA training to its staff on an annual basis, and maintain policies and procedures and a Code of Conduct addressing FWA. Records of training and distribution of FWA material must be maintained for 10 years. Doctors HealthCare Plans or CMS, may request documentation to verify compliance.

Doctors HealthCare Plans ensures that fraud alerts (including HPMS memos and OIG notifications) issued by
regulatory or law enforcement entities are available to providers through the Web Site or bulletins in order to raise awareness and bring any alleged FWA activity into focus.

Providers sanctioned by the OIG and/or GSA will terminated from the network. In order to manage this, designated departments will review the exclusions lists at the Office of the Inspector General (OIG) at the Department of Health & Human Services (DHHS) and General Services Administration (GSA) and act upon it as necessary.

**REPORTING**

Potential FWA situations should be reported immediately through the available channels:

- FWA Hotline: (833) DHCP911 or (833) 342-7911
- FWA e-mail: reportfraud@doctorshcp.com
- Compliance Helpline: (833) 500-3427
- Compliance e-mail: compliance@doctorshcp.com

These channels are confidential and available 24 hours a day, 7 days a week. Calls maybe made anonymously. Doctors HealthCare Plans follows a non-retaliation/non-retribution policy and prohibits any form of retaliation or harassment against anyone that make a report in good faith.

**PREVENTION & DETECTION OF FWA**

Doctors HealthCare Plans, Inc. has a Claims processing system and additional software applications that help detect duplicate billing, incorrect coding, validity of procedures, validity of diagnosis codes, services not justified by diagnosis, bundling of procedures, billing of incidental procedures, validation of diagnosis according to gender and age, etc. The Plan will reject claims that do not meet Medicare criteria and has established a claims audit and recovery mechanisms to recover amounts for claims previously paid in error.

Please help us fight FWA by notifying our FWA Department if you become aware of any suspected FWA. Examples include but are not limited to:

- A member who intentionally permits others to use his/her identification card to obtain services or supplies
- A member knowingly provided fraudulent information on his/her enrollment form that materially affects the member’s eligibility
- A provider falsifying information that has been submitted through a prior authorization or coverage determination
- A pharmacy intentionally providing less than the prescribed amount without letting the patient know and billing plan for the full amount (drug shorting),
- A pharmacy dispensing counterfeit or adulterated drugs, dispensing without a prescription, prescription refill errors, inappropriate billing practices, etc.
- Theft of your DEA number or prescription pad
- Kickbacks, inducements and other illegal remuneration
- Billing for services not rendered
- Fraudulent or inappropriate billing
- Utilization patterns outside the norm
SPECIAL INVESTIGATIONS
The Special Investigations Unit (SIU) within the FWA Department is tasked with investigating alleged fraud situations. Special investigations are conducted expeditiously and in a confidential manner.

All providers are expected to collaborate with a special investigation and deliver all necessary information on request. The results of a special investigation are strictly confidential and are presented to the Doctors HealthCare Plans, Inc. senior management.

II. EXCLUSIONS CHECKS

All exclusion screening must be performed, prior to hire or contract and monthly thereafter. Records on exclusion checks must be maintained for 10 years. Doctors HealthCare Plans as well as CMS, may request documentation of the exclusion checks at any time to verify they were completed.

OIG & SAM
Individuals and entities must be screened against both the Office of Inspector General (OIG), List of Excluded Individuals and Entities (LEIE) and exclusion records accessed through the System for Award Management (SAM), formally known as GSA. Doctors HealthCare Plans, as well as their “first tier, downstream, and related entities” (FDRs), must make sure potential employees and anyone involved in administration or delivery of Doctors HealthCare Plans benefits and services, are not excluded from participating in federal health care programs. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers, and sub delegates. You must review federal (HHS-OIG and SAM) and state exclusion lists, as applicable. Information can be found at:

- General Services Administration (GSA) System for Award Management at: https://www.sam.gov/SAM/

CMS PRECLUSION LIST
The Centers for Medicare and Medicaid Services (CMS) has a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Information can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/PreclusionList.html. The Preclusion List is a list of prescribers and individuals or entities who fall within any of the following categories:

1. Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or

2. Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Such conduct includes, but is not limited to, felony convictions and Office of Inspector General (OIG) exclusions.

This list is effective for claims with dates of service on or after January 1, 2019.

Providers receive notification from CMS of their placement on the Preclusion List, via letter, and will have the opportunity to appeal with CMS before the preclusion is effective. These appeal rights allow a provider to challenge CMS’ placement of the provider on the list. The preclusion appeals process will neither include nor affect appeals of payment denials or enrollment revocations, as there are separate appeals processes for these actions. Impacted
providers with questions regarding the letter may contact CMS directly via email at providerenrollment@cms.hhs.gov.

Once the preclusion date is effective, claims will no longer be paid, pharmacy claims will be rejected, and the network provider will be terminated from Doctors HealthCare Plans network.

Doctors HealthCare Plans will ensure payments for health care services or items are not made to individuals or entities on the Preclusion List, including employed or contracted individuals or entities. Doctors HealthCare Plans will share list appropriately with delegates and ensure their review.

III. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI)

The privacy and security of our member’s information is a priority for Doctors HealthCare Plans and should be a priority for all health care companies, clinicians and medical professionals and clearinghouses. The Health Insurance Portability and Accountability Act (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. Protected Information (PI) - Data elements that could identify or reasonably identify an individual.

- **Personally Identifiable Information (PII)** - Information that, when used alone or with other relevant data, can identify an individual.

- **Protected Health Information (PHI)** - Information about health status, provision of health care, or payment for health care that is created or collected and can be linked to a specific individual. This includes; medical records and other information that identifies a member, including demographic, medical, and financial information in any form.

- **Protected Financial Information (PFI)** - Includes PI and financial information such as credit card number, bank account number, premium billing.

Violations should be avoided by implementing Health Insurance Portability and Accountability Act (HIPAA) regulations into practice policies and procedures and ensuring that all individuals with access to patient information receive the proper training. Doctors HealthCare Plans, and all health care providers are required, under HIPAA Privacy Rule, to protect and keep confidential any PHI. It also sets limits and conditions on information use and disclosure without patient authorization. The Rule also gives patients the right to their health information, including rights to obtain a copy of their medical records, and request corrections. Reasonable efforts must be made to limit PHI as defined under the HIPAA Privacy Rule, to the minimum necessary when using or disclosing PHI. The minimum necessary standard is not intended to impede activities related to treatment, payment or health care operations (TPO). The Privacy Rule requires written member authorization for uses and disclosure that fall outside of the TPO. You do not need a written authorization from your patients who are or have been members of Doctors HealthCare Plans to disclose their medical information to us for HEDIS and other quality improvement, accreditation or regulatory activities (Section 164.506(c)(4) of the HIPAA Privacy Rule). HIPAA regulates the use, transfer, and disclosure of identifiable health information. Additional information can be found on the U.S. Department of Health & Human Services sites:

Please report all privacy issues or breaches immediately to Compliance so we can investigate and respond appropriately. Please see Provider Services Quick Reference Guide for contact information. Examples include but not limited to:

- Reports and correspondence containing PHI sent to the wrong recipient
- Complaint received indicating PHI or PII may have been misused
- Lost or theft of laptops, PDAs, CDs, DVDs, flash/USB drives and other electronic devices
ATTACHMENTS
Internal Risk Management Program Orientation & Training

OBJECTIVES
The Participant Shall, upon completion of the orientation and training, perform the following:

• List examples of reportable events.
• Identify Agency for Health Care Administration (AHCA) Code 15 Report.
• Complete and file an Incident Report.
• Know who to report to and how to contact the Risk Manager.
• Understand Insurance carrier reports.
• Understand internal and external corporate attorney roles.
• Identify employee/associate role in the Risk Management/reporting.
• Recognize actions that are potentially illegal.
• Recognize potential litigation events.
• Understand current influences.

AGENCIES & ACCREDITATION
State Law under §641.55, F.S.: Internal Risk Management (RM) Program, requires all HMO employees to complete RM Program training and comprehend Program objectives, grievance procedures, incident reports, and reporting requirements, including Code 15.

• OIR - Office of Insurance Regulation
• AHCA - Agency for Health Care Administration
• AAAHC - Accreditation Association for Ambulatory Health Care, Inc

RISK MANAGEMENT PROGRAM REQUIREMENTS
• Risk Manager – Appointed by Board
• Risk Management Program Implementation/Oversight
• Risk Management Committee
• Risk Management Policy & Procedures
• Risk Management Reporting
• Incident Report
• Code 15 Reports
• Internal Resource
RISK MANAGEMENT
The Risk Management Process:

- Identify Risks (including near-misses)
  - Actual or potential financial risk or losses throughout the organization, including contracted providers.
- Investigate & Analyze
- Plan/Select appropriate RM Techniques
- Implement Selected RM Techniques
- Monitor Results & Identify Any Required Revisions to RM Program
- Prevent Recurrence
- Report to Committee/Board

WHY & WHAT YOU NEED TO REPORT!
By law and internal policies, it is the affirmative duty of ALL EMPLOYEES to report Adverse Incidents and other Reportable Events to the Risk Manager, including near-miss events:

- Any event that results or potentially results in an injury.
- Any event that is considered an adverse event or code 15.
- Any event that appears to violate a regulatory requirement.
- “Notice of intent” or lawsuits, letters from attorney, letters of representation, summonses or complaints.
- Verbal or written threats/demands – violent behavior.
- Health care fraud by providers or plan operations.
- Misuse or misappropriation of resources.
- Any event that is in violation of the organizational rules, or policy such as theft or misconduct.

WHAT IS AN ADVERSE EVENT?
- A member health care encounter during which an unexpected occurrence results in, for example, the death of a member, serious physical or psychological injury or illness, or the loss or function of a limb not related to the natural course of an illness or underlying condition.
- Process variation which carries the significant chance of a serious adverse outcome.
- Breaches in medical care or administrative procedure that result in outcomes not associated with standard of care or acceptable risks for the delivery of such care or services, including reactions to medication and materials.
- Identification of “near miss” circumstances, events, and care episodes that have the potential to result in adverse incidents.

SOURCES OF REPORTABLE INFORMATION
- Witness to risk exposure
- Review of cases, statements, issues
- Facility performance improvement processes and medical records reviews
- Physician meetings
- Patient complaints/grievances
- Rumors
TYPE OF ADVERSE EVENTS
Requirements under F.S. 641, AHCA, include clinical (medical) components of care employee and provider education. The company does not perform clinical duties of a staff model HMO, however, education includes clinical areas of understanding. Contracted providers may incur reportable events.

Type of Events

Based on Office of Insurance General/Department of Health and Human Services (OIG/HHS)

- **ADVERSE EVENT:** An event, preventable or nonpreventable, that caused harm to a patient as a result of medical care. This includes never events; hospital-acquired conditions; events that required life-sustaining intervention; and events that caused prolonged hospital stays, permanent harm, or death.

- **NEVER EVENT:** A serious event, such as surgery on the wrong patient, that the National Quality Forum included on a specific list of events that “should never occur in a health care setting.”

- **TEMPORARY HARM EVENT:** An event that requires intervention but does not cause lasting harm, such as an allergic reaction or hypoglycemia.

CODE 15 REQUIRED STATE REPORTING

Required Reports to the Agency for Health Care Administration (AHCA)

- Code 15 Reports
- Annual Reports
- Department of Health Reports (physician practices)

Reportable incidents are events where health care personnel could exercise control and is associated in whole or part with medical intervention, rather than the condition for which such intervention occurred and results in one of the following reportable to AHCA within 15 days...

- Death of a patient.
- Brain or spinal damage to a patient.
- Performance of surgical procedure on wrong patient.
- Performance of wrong-site surgical procedure.
- Performance of wrong surgical procedure.
- Performance of a surgical procedure that is medically unnecessary or unrelated to the patient’s medical condition.
- Performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.
- Surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient.

PREVENTION FOR CLINICAL & MEDICAL RECORDS

Notes for Providers and Facility In-Services:

- Do not attempt any procedure without adequately training.
- Strong, positive rapport with patients.
- Make sure all information is accurate/recorded (initialized), tracked, communicated to patient, and documented.
• Document how patient was made aware of positive test results.
• Don’t file any test result that the physician has not seen and initialed.
• Track test orders, receipt of results, and patient communication.
• Never leave a message related to test results on an answering machine!
• Medical Record contents and order of documents should be consistent.
• Clinical records should be concise.
• Continuity of Care (how referrals are made and their results).
• Give reason for referrals.

RISK CONTROL
There are actions you can take/not take to decrease risk exposure:

• Do Not discuss patient complaints or care issues in a non-private setting
• Do Not discuss ongoing claims (intents or lawsuits) with anyone without a corporate attorney’s approval.
• Do Not speak with any attorney without prior approval from the Risk Manager/corporate attorney.
• Do Not use judgmental words.
• DO document clear, factual accounts.
• DO remain diligent in your work and observations.
• DO remain aware of your surroundings and conversations.
• DO report - better “safe than sorry.”

NEGLIGENCE VS MALPRACTICE
Administrative delays related to health plan activities are NOT Malpractice, but may be considered Negligence.

Negligence is determined when the following is present:

(The Four D’s)
- Duty: Enrollee/Patient is due a standard of care
- Dereliction of that duty (standard was not provided)
- Direct result (the plan was responsible for the proximal cause)
- Damage resulted due to dereliction of the duty

HOW TO REPORT
• Complete Incident Report - Form available on DHCP Public Drive in Risk Management Folder (P:\Risk Management)
  - Remember the Incident Report is a CONFIDENTIAL document
    » Identify person, place, issue using complete/concise information and facts
    » Include your signature, date, department, and phone
    » Send ORIGINAL to Risk Manager – NEVER make a copy
• Report within 24 hours of knowledge of event
  – RM must report to AHCA within 3 business days
  – For Serious Events contact RM immediately
    » This includes never events; hospital-acquired conditions; events that required life-sustaining intervention;
    and events that caused prolonged hospital stays, permanent harm, or death.
• Do not need permission to file an incident report.
  – State requirement that no one interferes with incident reporting
    » Fines may be imposed for interference

NOTES ABOUT “WHO IS WATCHING/LISTENING”
Be aware in today’s electronic environment, that people have access to recording and video devices and can
monitor your activities without your knowledge.

• Don’t want your personal information to make it to YOUTUBE!
• Use your “smarts” and “caution” when on the phone, or meeting with members, etc.
• General rule of thumb: assume someone, somewhere is recording you and act accordingly.
• NEVER DISCUSS COMPANY BUSINESS intentionally or inadvertently via phone, in public, elevators, etc, or
  outside the work environment!

SOCIAL MEDIA
Be aware in today’s electronic environment, that people have access to recording and video devices and can
monitor your activities without your knowledge.

• Be very cautious of your activities on social media sites, such as, but not limited to: Facebook, Twitter,
  Instagram, Blogs, etc.
• NEVER discuss company and/or member information.
• NEVER post work related pictures or data.
• Be aware of what you put “out there.” It may be seen, interpreted, or used in a way you did not intend, and
  may have repercussions, even after a long period of time has lapsed.
• Fortune 500 and other companies, associations, and colleges, may research the web prior to employment
  or enrollment!

CONFIDENTIALITY
You must maintain confidentiality of member data in compliance to the HIPAA and other applicable laws.

This includes employee health information.

IN CLOSING
Fill out an Incident Report if YOU BELIEVE OR SUSPECT that something has occurred, or may occur, that puts a
member, the plan, an employee, or department at risk.

• Remember that it is just as important to report near miss events in order to mitigate future risks.
YOUR RISK MANAGEMENT RESOURCES
Fill out an Incident Report if **YOU BELIEVE OR SUSPECT** that something has occurred, or may occur, that puts a member, the plan, an employee, or department at risk.

- Direct: (786) 584-8335 x967
- Email: riskmanager@doctorshcp.com
  - Subject line: “REQUEST TO SPEAK TO YOU”
  - Email body: your name, number to reach you
  - DO NOT INCLUDE ANY INFORMATION REGARDING YOUR REQUEST

SEND COMPLETED INCIDENT REPORT TO:
- Confidential Fax: (786) 578-0284 (for prompt receipt); and
- Provide the original Form in person to Risk Manager or mail to:
  
  **ATTENTION: Risk Manager/Confidential**
  Doctors HealthCare Plans, Inc.
  2020 Ponce de Leon Blvd., PH 1
  Miami, FL 33134

RISK TRAINING ACKNOWLEDGMENT FORM
Thank you for completing your Risk Management Training!

Please print out the Risk Training Acknowledgment Form attached in your email, complete, and send it back to SNP@doctorshcp.com
Special Needs Plans (SNP) Model of Care Training

OUR MISSION
To develop and establish a health care organization that is responsive and attentive to the needs of all Medicare beneficiaries by offering high quality, cost-effective health care services.

TRAINING OBJECTIVES
- Comprehension of our Special Needs Plans (SNPs) components and benefits
- Understanding how Members qualify for SNP
- Review components of SNP Model of Care (MOC)
- Communicate training and comprehension requirements
- Explain SNP Care/Case Management processes and philosophy
- Describe Health Risk Assessment (HRA) Process
- Review Quality Outcomes & Measures
- Describe Roles & Responsibilities
- Provide information about DHCP SNP Resources

SNP MODEL OF CARE (MOC)
A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP), specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be any one of the following:

- An institutionalized individual,
- A dual eligible, or
- An individual with a severe or disabling chronic condition, as specified by CMS.

A SNP may be any type of MA CCP, including either a local or regional preferred provider organization (i.e., LPPO or RPPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO-POS) plan. There are three different types of SNPs:

- Chronic Condition SNP (C-SNP)
- Dual Eligible SNP (D-SNP)
- Institutional SNP (I-SNP)
SPECIAL NEEDS PLANS (SNPS) PROGRAMS
DHCP MOC is designed to ensure the provision and coordination of specialized services that meet the needs of the SNP eligible beneficiaries.

Doctors HealthCare Plans (DHCP) offers three Special Needs Plans for 2020:

Medicare-Medicaid Dual Eligible Program (D-SNP)
- Dual Eligible
  - DrPlus (002)

Chronic Disease Programs (C-SNP)
- Chronic Heart Failure
  - DrCare (003)
- Diabetes Mellitus
  - DrExtra (004)

Our C-SNP plans focus on providing Members with education about their disease, self-management/care, medication, and nutrition.

SNP PROGRAM MISSION & MOC GOALS

Our SNP Program Mission:
The DHCP SNP Programs are designed to maximize the quality of care, access to care, and health outcomes for the SNP populations it serves.

Our Overall Model of Care (MOC) Goals include:
- Improve access to essential services
- Improve access to affordable care
- Improve coordination of care
- Improve transitions of care
- Improve access to preventive health services
- Facilitate appropriate utilization of services
- Improve beneficiary health outcomes
- Engage provider network in DHCP support services

SNP Model of Care (MOC)
DHCP Model of Care Provides Members with:
- Interdisciplinary Care Team (ICT) to Coordinate Care
- Individualized Care Plan (ICP) for each Member
- Specialized Provider Network
- Integrated Communication Systems
- Additional Benefits
- Coordination of Care
• Care Transition Management
• Case Management for all Members
• Annual Health Risk Assessments
• Coordination of Benefits for all Members
• Quality Improvement Program
• Chronic Care Improvement Program

HEALTH SERVICES
Plan benefits and the Models of Care (MOCs) are designed to optimize the health and wellbeing of Members, particularly our aging, vulnerable, and chronically ill individuals by:

• Matching interactions with member needs in their current state of health.
• Identifying care needs through a comprehensive initial assessment and annual reassessments.
• Creating Individualized Care Plans (ICP) with goals and measurable outcomes.
• Building an Interdisciplinary Care Team (ICT) to meet these needs.
• Ensuring Providers are involved in care decisions.
• Effectively managing utilization.
• Improve access to affordable medical, mental health, and social services.

SNP MODEL OF CARE (MOC) ELEMENTS
SNP Model of Care is the overall plan for SNP structure, processes, resources, and requirements.

There are four (4) Model of Care Elements:

  Target Population
  Care Coordination
  Provider Network
  Quality Measurement

SNP MODEL OF CARE (MOC 1): OVERALL SNP POPULATION
SNP MOCs must identify and describe the target population, including health and social factors, and unique characteristics of each SNP type.

Our MOCs:

• Provide a foundation upon which the remaining measures build a complete continuum of care (e.g., end-of-life & special considerations) for current and potential members DHCP intends to serve
• Describe how DHCP staff will determine, verify and track eligibility of SNP beneficiaries
• Describe the social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP population
• Identify and describe the medical and health conditions impacting SNP beneficiaries
• Define the unique characteristics of the SNP population served
Capture Most Vulnerable Beneficiaries:

- Important to note that the focus is on population-level, not individual members:
  - What makes them “different from the general population?”
  - Include specially tailored services for members considered “most vulnerable” (e.g. multiple hospital admissions or excessive spending on medications above set limits)
  - Go above and beyond those services provided to the general population
- Defines and identifies the most vulnerable beneficiaries within the SNP population and provides a complete description of specially tailored services for such beneficiaries
- Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries
- Illustrates a correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements
- Identifies and describes established relationships with partners in the community to provide needed resources

It’s important to note, that while national statistics provide some idea of the chronic diseases and comorbidities certain populations face, the population description must speak specifically to each SNP’s target population for the service area.

DOCTORS HEALTHCARE PLAN (MOC 1): OVERALL SNP POPULATION(S)

Dual Eligible — DrPlus

A. Medicaid Eligible
   - This population has a high prevalence of physical and mental health conditions.

B. Most Vulnerable Population
   - Members who are frail
   - Members who are disabled
   - Members who have multiple chronic illnesses
   - Members who have had multiple hospitalizations or skilled nursing facility admissions
   - Members who are at the end of their life

All our Members are particularly vulnerable due to barriers they encounter related to ethnicity, health literacy, and socio-economic status.

Diabetes Mellitus — DrExtra

A. Dx-Diabetes
   - This population commonly has comorbidities; a study of data reported that only 25% of Medicare Part B beneficiaries have diabetes without comorbidity
   - Patients in this population have complex needs and are more likely to see multiple providers, which can result in fragmented sub-optimal care coordination that can increase acute or emergency utilization.

B. Most Vulnerable Population
   - Members who are frail
   - Members who are disabled
- Members who have multiple chronic illnesses
- Members who have had multiple hospitalizations or skilled nursing facility admissions
- Members who are at the end of their life
- Members who are diabetic with complications

**Chronic Heart Failure — DrCare**

**A. Dx-Chronic Heart Failure**
- This population commonly has comorbidities; a study from the American Heart Association reported that nearly 40% of CHF patients also have 5 or more non-cardiac health conditions, which account for 81% of the total CHF inpatient days.
- Patients in this population have complex needs and are more likely to see multiple providers, which can result in fragmented sub-optimal care coordination that can increase acute or emergency utilization.

**B. Most Vulnerable Population**
- Members who are frail
- Members who are disabled
- Members who have multiple chronic illnesses
- Members who have had multiple hospitalizations or skilled nursing facility admissions
- Members who are diabetic with complications
- Members who have a diagnosis of heart failure with complications

**SNP MODEL OF CARE (MOC 2): SNP STAFF STRUCTURE**

SNP MOCs must identify the staff structure and describe the administrative and clinical staff roles and responsibilities.

Our MOCs:

- Describe staff structure and functions
  - Administrative staff roles and responsibilities, including oversight functions
  - Describe the clinical staff roles and responsibilities, including oversight functions
  - Describe how staff responsibilities coordinate with the job title
  - Describe contingency plans used to address ongoing continuity of critical staff functions
- Describe how the organization conducts initial and annual MOC training for its employed and contracted staff
  - Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training
  - Describe actions the organization takes if staff does not complete the required MOC training
- Include an organizational chart
SNP MODEL OF CARE (MOC 2): SNP STAFF STRUCTURE

Our Organizational Chart

SNP Medical Director

SNP Analyst

SNP Administrative Director

SNP Member Service Rep(s).

SNP Reporting Analyst

SNP Network Manager

SNP Claims Analyst

SNP Enrollment Specialist

SNP Delegation Oversight Manager

SNP Fulfillment Coordinator

SNP Credentialing Specialist

SNP Clinical Director

SNP Social Worker(s)

SNP RN Quality Coordinator

SNP Pharmacy Director/ Specialist

SNP Care/ Disease Manager(s)

SNP Behavioral Health Care Manager(s)

SNP Member Engagement Coach(es)
SNP MODEL OF CARE (MOC 2): SNP MOC TRAINING
DHCP conducts initial and annual training regarding the DHCP SNP MOC for employed and contracted staff.

Training Standards & Requirements

- Initial training to be completed within 30 days from hire and each calendar year thereafter.
  - Training may be provided in person or online through self-study.
- Attestation to training completion is required.
  - Confirming name, title, and date of training
- Training evaluation must be completed.

SNP MODEL OF CARE (MOC 2): MEDICARE & MEDICAID COORDINATION
D-SNP Coordination goals include:

- Members are informed of benefits offered by both programs.
- Members are provided with information on how to maintain Medicaid eligibility.
- Members have access to staff that is knowledgeable of programs and community resources.
- Plan provides clear communication regarding claims and cost-sharing from both programs.
- Members are informed of rights to pursue appeals and grievances through both programs.
- Members are provided information on how to access providers that accept Medicare and Medicaid.

SNP MODEL OF CARE (MOC 2): INTEGRATED SERVICES
DHCP has contracted vendors to provide health and case management services. To inquire about our current vendors, please contact your Provider Relations Representative.

SNP MODEL OF CARE (MOC 2): CASE MANAGEMENT PROGRAM
DHCP Case Management Program includes:

- Case/Care Management
- Disease Management
- Coordination of Services
- Transitions of Care Services
- Special Needs Program Case Planning

The Case Management Staff includes:

- Physicians
- Pharmacists
- Registered Nurses
- Health Coaches
- Social Workers
SNP MODEL OF CARE (MOC 2): CASE MANAGEMENT

DHCP assigns a Case Manager to each SNP Member to assist with the Member’s health care needs and:

- All SNP members are enrolled in case management.
- Each member has an individualized care plan developed.
- Members may opt out of case management but remain assigned to a Case Manager.
- Members are stratified according to their risk profile to focus resources on the most vulnerable.

SNP MODEL OF CARE (MOC 2): HEALTH RISK ASSESSMENTS (HRA)

All SNP Members receive a Health Risk Assessment (HRA).

*Code of Federal Regulations (42 CFR §422.101(f)(i); 42 CFR §422.152(g)(2)(iv)) require that all SNPs conduct a Health Risk Assessment for each individual enrolled in the SNP.*

Our HRAs are used to:

- Identify Individual Health Needs
- Risk Stratify Members for Service
- Nominate Members for Disease or Case Management Programs
- Initiate Care Plans
- Communicate with Physicians, Interdisciplinary Care Team (ICT), Members, Care Givers, and Ancillary Providers

Our HRAs are completed by:

- Mail
- Phone Call
- Online (in development)
  - A comprehensive initial assessment is completed within ninety (90) days of enrollment.
  - An annual reassessment of the individual’s medical, physical, cognitive, psychosocial and functional, and mental health needs, is also conducted.
  - Members will be educated on their right to an Advanced Directive and Durable Power of Attorney, if necessary, and additional information will be sent to them regarding these topics if they desire.

SNP MODEL OF CARE (MOC 2): HEALTH RISK ASSESSMENTS (HRA)

- HRA Completed
- HRA to SNP Case Manager
- HRA Entered into System
- HRA Scanned into System as Electronic Image
- Case Mgr uses HRA to determine Mbr Risk Level within the SNP
- ICT reviews, analyzes, and stratifies Mbr health care needs at time of enrollment and upon reassessment
- HRA stratification results are incorporated into Mbr’s Individual Care Plan (ICP)
- Care Plans and results of stratification results are provided to Mbr’s PCP and the Mbr or Caregiver is provided a copy.
Risk Levels:
1. New Hospitalizations regardless of primary Dx and increased symptoms compared to baseline
2. Stable symptoms, at previous level of functioning, no hospitalizations in past 2 months (or 1 if enrolled in Health Coaching Program)
3. Stable symptoms, at previous level of functioning, no hospitalizations in past 3 months (or 2 if enrolled in Health Coaching Program)
4. Stable symptoms, at previous level of functioning, no hospitalizations in past 6 months (or 3 if enrolled in Health Coaching Program)
5. No hospitalizations

SNP MODEL OF CARE (MOC 2): INDIVIDUALIZED CARE PLAN (ICP)
Code of Federal Regulations (42 CFR §422.101(f)(ii); 42 CFR §422.152(g)(2)(iv)) requires all SNPs to develop and implement an ICP for each individual enrolled in SNP.

- The DHCP Case Manager creates the Member’s ICP
- The Member and/or their caregiver is involved in the development of their Care Plan
- The ICP is based on the Member’s HRA and any identified opportunities
- The ICP is prioritized to consider the Member’s preferences and their desired level of engagement
- The ICP is updated to reflect any change in the Member’s medical and psychosocial status
  - Revision includes evaluation of identified goals and whether they are met
- The ICP is communicated for coordination of care and when there is a transition to a new care setting, such as a hospital or Skilled Nursing Facility (SNF)
- The ICP is also provided to PCP and Member/Caregiver

SNP MODEL OF CARE (MOC 2): INTERDISCIPLINARY CARE TEAM (ICT)
Code of Federal Regulations (42 CFR §422.101(f)(iii); 42 CFR §422.152(g)(2)(iv)) require that all SNPs use an ICT in the care management of each individual enrolled in the SNP.

The DHCP ICT contributes to improving beneficiary health status and they meet regularly to manage the medical, cognitive, psychosocial and functional needs of the Member.

The Member and/or Caregiver is included on the ICT.

ICT Members:
- SNP Medical Director
- SNP Clinical Director
- Social Services Specialist
- Case Management Director
- Case Managers
- Clinical Supervisor
- Pharmacist
- Behavioral Health Specialist
- Network Practitioners
- Social Worker
Optional Team Members:

- Specialty Providers
- Nurse Practitioners
- Pastoral Care
- Palliative Care HC
- Home Care
- Dietician/Nutritionist

SNP MODEL OF CARE (MOC 2): MANAGEMENT OF CARE TRANSITIONS

Members can be faced with significant challenges when moving from one setting to another. The management of transitions is focused on supporting our Members with their treatment plan as they move from one setting to another to prevent re-admissions or delay of care needs.


Personnel Involved in Coordinating Care Transitions

- Utilization Clinical Review Staff
- Case manager
- Transition Case Manager/Additional Support Staff
- Social Worker

Our in-patient (IP) concurrent review and care coordination processes allow us to identify transition of care needs.

Clinical staff coordinate with providers to assist Members in the hospital, SNF, or other setting to access care as appropriate.

The SNP Case Managers and Social Workers ensure Members have appropriate follow-up care after transition to any new setting.

SNP MODEL OF CARE (MOC 3): PROVIDER NETWORK

Code of Federal Regulations (42 CFR§422.152(g)(2)(vi)) require SNPs to demonstrate that the provider network has specialized clinical expertise in delivery of care to beneficiaries.

The DHCP provider network is comprised of specialized expertise which corresponds to our target population.

- DHCP oversees its provider network and facilities and oversees that its providers are competent and have active licenses
- How the SNP documents, updates and maintains accurate provider information
- How providers collaborate with the ICT and contribute to a beneficiary’s ICP to provide necessary specialized services
Regulations at (42 CFR§422.101(f)(2)(ii)) require that SNPs conduct MOC training for their network of providers. DHCP complies with the network training requirements:

• Requiring initial and annual trainings for network providers
  – During the new and annual provider orientations, in which providers are given the Model of Care training, provider manual, drug formulary, provider directory, and referral authorization form, providers complete the Provider Orientation sign-in sheet and an attestation of training. Similarly, non-network providers, who have seen over 5 DHCP members or who have 5 encounters with members are also sent the MOC training information by mail and asked to submit an attestation confirming their review of the information.

• Documenting evidence that the organization makes available and offers MOC trainings for network providers.

• Monitoring challenges associated with completion of MOC trainings for improvement opportunities.

• Taking action when the required MOC training is deficient or has not been completed.

SNP MODEL OF CARE (MOC 4): QUALITY IMPROVEMENT PROGRAM (QIP)
Code of Federal Regulations (42 CFR §422.152(g)) require that all SNPs conduct a Quality Improvement Program (QIP) that measures the effectiveness of its MOC.

DHCP Quality Improvement Program (QIP) monitors health outcomes and implementation of SNP MOCs:

• Collecting SNP specific HEDIS® measures.

• Meeting SNP Structure and Process standards.

• Conducting QIP reviews that focus on improving clinical services as they relate to our SNP population (i.e., Fall Prevention).

• Providing a chronic care improvement program for chronic disease that identifies eligible members, intervenes to improve disease management, and evaluates program effectiveness.

• Collecting data to evaluate if SNP and MOC goals are met.
  – Using encounter data, HRAs, CAHPS, HOS and other methodologies as needed for data collection.
  – Actions are taken when goals are not met.
  – QIC investigates to determine actions required.
    » What was the root cause or factors that resulted in not meeting goals? Time frame, goal too broad or too specific?

• The Quality Improvement Committee is comprised of our Medical Director and various departmental directors and unit supervisors (both internally and externally), as well as external experts for a comprehensive and effective internal quality performance process. The SNP Director works with the departments to collect, analyze, and report on data for evaluation of the MOC. Different reports are generated based on the specific needs and initiatives as requested by Committee to meet MOC standards and other improvement initiatives.
  – Support from our PBM, BH, and Vision Vendors is a must to effectively measure performance.

• DHCP evaluates Program effectiveness annually at a minimum to identify results from performance indicators, including lessons learned and challenges for the support of ongoing Program improvements.

• Evaluation results provided to Board and key stakeholders annually at a minimum.
ADDITIONAL RESOURCES
Additional Resources Include:

- DHCP Portal
  - Member Portal
  - Provider Portal
- Materials, including:
  - Health Risk Assessment
  - DHCP Quality Goals, Measures, and Activities Guide
- CMS SNP and Related Links
- Office and Individual Training and Materials
  - Health & Wellness Programs
  - Disease Specific Materials
  - Interaction with a certified health educator or other qualified individual

IN-CLOSING
It is important that the entire DHCP Team, including our internal staff, our Members, and our network of providers, work together to successfully meet our SNP MOC mission and goals.

THANK YOU!!!
Thank you for participating in our 2020 SNP MOC Training Program.

To evaluate your training, please complete the following steps:

- Print, review, and complete the following from Doctors website under Download Template Forms:
  - MOC Training Attestation Form; and
  - MOC Training Evaluation Form.
- Email the two completed Forms to Director of Special Needs Plans at SNP@doctorshcp.com or fax to (786) 279-8208
DrPlus – MEDICAID SERVICE-SPECIFIC POLICIES

Doctors HealthCare Plans’ Participating Providers acknowledge that when rendering services and care to a DrPlus enrollee they must comply with the following prevailing standards, and understand that in rendering services or care to a DrPlus enrollee, they thereby agree to maintain compliance with applicable rules and standards in doing so:

Note: In an electronic format, selecting the rule name hyperlink will redirect you to the Florida Administrative Register’s (FAR) website. Selecting the PDF hyperlink under reference material will retrieve the most recently promulgated reference material associated with the rule.

<table>
<thead>
<tr>
<th>RULE NUMBER</th>
<th>RULE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>59G-13.015</td>
<td>Adult Cystic Fibrosis Waiver Services Procedure Codes and Fee Schedule</td>
</tr>
<tr>
<td>59G-4.013</td>
<td>Allergy Services</td>
</tr>
<tr>
<td>59G-4.020</td>
<td>Ambulatory Surgical Center Services</td>
</tr>
<tr>
<td>59G-4.022</td>
<td>Anesthesia Services</td>
</tr>
<tr>
<td>59G-4.025</td>
<td>Assistive Care Services</td>
</tr>
<tr>
<td>59G-4.125</td>
<td>Behavior Analysis Services</td>
</tr>
<tr>
<td>59G-4.028</td>
<td>Behavioral Health Assessment Services</td>
</tr>
<tr>
<td>59G-4.031</td>
<td>Behavioral Health Community Support Services</td>
</tr>
<tr>
<td>59G-4.370</td>
<td>Behavioral Health Intervention Services</td>
</tr>
<tr>
<td>59G-4.029</td>
<td>Behavioral Health Medication Management Services</td>
</tr>
<tr>
<td>59G-4.027</td>
<td>Behavioral Health Overlay Services</td>
</tr>
<tr>
<td>59G-4.052</td>
<td>Behavioral Health Therapy Services</td>
</tr>
<tr>
<td>59G-4.033</td>
<td>Cardiovascular Services</td>
</tr>
<tr>
<td>59G-8.700</td>
<td>Child Health Services Targeted Case Management</td>
</tr>
<tr>
<td>59G-4.040</td>
<td>Chiropractic Services</td>
</tr>
<tr>
<td>59G-4.050</td>
<td>Community Behavioral Health Services</td>
</tr>
<tr>
<td>59G-13.088</td>
<td>Consumer-Directed Care Plus Program</td>
</tr>
<tr>
<td>59G-4.055</td>
<td>County Health Department Clinic</td>
</tr>
<tr>
<td>59G-4.060</td>
<td>Dental Services</td>
</tr>
<tr>
<td>59G-13.070</td>
<td>Developmental Disabilities Individual Budgeting Waiver Services</td>
</tr>
<tr>
<td>59G-4.105</td>
<td>Dialysis Services</td>
</tr>
<tr>
<td>59G-8.600</td>
<td>Disenrollment from Managed Care Plans</td>
</tr>
<tr>
<td>59G-4.070</td>
<td>Durable Medical Equipment and Medical Supplies</td>
</tr>
<tr>
<td>59G-4.085</td>
<td>Early Intervention Services</td>
</tr>
<tr>
<td>RULE NUMBER</td>
<td>RULE NAME</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>59G-4.015</td>
<td>Emergency Transportation Services</td>
</tr>
<tr>
<td>59G-4.087</td>
<td>Evaluation and Management Services</td>
</tr>
<tr>
<td>59G-4.100</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>59G-4.026</td>
<td>Gastrointestinal Services</td>
</tr>
<tr>
<td>59G-4.108</td>
<td>Genitourinary Services</td>
</tr>
<tr>
<td>59G-4.110</td>
<td>Hearing Services</td>
</tr>
<tr>
<td>59G-13.075</td>
<td>Home and Community Based Services Settings</td>
</tr>
<tr>
<td>59G-4.130</td>
<td>Home Health Services</td>
</tr>
<tr>
<td>59G-4.132</td>
<td>Home Health Electronic Visit Verification Program</td>
</tr>
<tr>
<td>59G-4.140</td>
<td>Hospice Services</td>
</tr>
<tr>
<td>59G-4.150</td>
<td>Inpatient Hospital Services</td>
</tr>
<tr>
<td>59G-4.032</td>
<td>Integumentary Services</td>
</tr>
<tr>
<td>59G-4.170</td>
<td>Intermediate Care Facility for Individuals with Intellectual Disabilities Services</td>
</tr>
<tr>
<td>59G-4.180</td>
<td>Intermediate Care Services</td>
</tr>
<tr>
<td>59G-4.190</td>
<td>Laboratory Services</td>
</tr>
<tr>
<td>59G-4.035</td>
<td>Medicaid Certified School Match Program</td>
</tr>
<tr>
<td>59G-4.058</td>
<td>Medicaid County Health Department Certified Match Program</td>
</tr>
<tr>
<td>59G-4.197</td>
<td>Medical Foster Care</td>
</tr>
<tr>
<td>59G-4.199</td>
<td>Mental Health Targeted Case Management</td>
</tr>
<tr>
<td>59G-4.201</td>
<td>Neurology Services</td>
</tr>
<tr>
<td>59G-4.330</td>
<td>Non-Emergency Transportation Services</td>
</tr>
<tr>
<td>59G-4.200</td>
<td>Nursing Facility Services</td>
</tr>
<tr>
<td>59G-4.318</td>
<td>Occupational Therapy Services</td>
</tr>
<tr>
<td>59G-4.207</td>
<td>Oral and Maxillofacial Services</td>
</tr>
<tr>
<td>59G-4.211</td>
<td>Orthopedic Services</td>
</tr>
<tr>
<td>59G-4.160</td>
<td>Outpatient Hospital Services</td>
</tr>
<tr>
<td>59G-4.222</td>
<td>Pain Management Services</td>
</tr>
<tr>
<td>59G-4.215</td>
<td>Personal Care Services</td>
</tr>
<tr>
<td>59G-4.320</td>
<td>Physical Therapy Services</td>
</tr>
<tr>
<td>59G-4.220</td>
<td>Podiatry Services</td>
</tr>
<tr>
<td>RULE NUMBER</td>
<td>RULE NAME</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>59G-4.255</td>
<td>Prescription Drug Coverage Denials</td>
</tr>
<tr>
<td>59G-4.250</td>
<td>Prescribed Drug Services</td>
</tr>
<tr>
<td>59G-4.260</td>
<td>Prescribed Pediatric Extended Care Services</td>
</tr>
<tr>
<td>59G-4.261</td>
<td>Private Duty Nursing Services</td>
</tr>
<tr>
<td>59G-13.112</td>
<td>Project AIDS Care Waiver Disposable Incontinence Medical Supplies Fee Schedule and Minimum Quality Standards</td>
</tr>
<tr>
<td>59G-13.110</td>
<td>Project AIDS Care Waiver Services</td>
</tr>
<tr>
<td>59G-4.266</td>
<td>Qualified Evaluator Network</td>
</tr>
<tr>
<td>59G-4.240</td>
<td>Radiology and Nuclear Medicine Services</td>
</tr>
<tr>
<td>59G-4.264</td>
<td>Regional Perinatal Intensive Care Center Services</td>
</tr>
<tr>
<td>59G-4.030</td>
<td>Reproductive Services</td>
</tr>
<tr>
<td>59G-4.322</td>
<td>Respiratory Therapy Services</td>
</tr>
<tr>
<td>59G-4.235</td>
<td>Respiratory System Services</td>
</tr>
<tr>
<td>59G-4.280</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>59G-4.290</td>
<td>Skilled Services</td>
</tr>
<tr>
<td>59G-4.324</td>
<td>Speech-Language Pathology Services</td>
</tr>
<tr>
<td>59G-4.300</td>
<td>State Mental Health</td>
</tr>
<tr>
<td>59G-4.120</td>
<td>Statewide Inpatient Psychiatric Program</td>
</tr>
<tr>
<td>59G-4.192</td>
<td>Statewide Medicaid Managed Care Long-term Care Program</td>
</tr>
<tr>
<td>59G-4.193</td>
<td>Statewide Medicaid Managed Care Long-term Care Waiver Program Prioritization and Enrollment</td>
</tr>
<tr>
<td>59G-4.310</td>
<td>Targeted Case Management for Children at Risk of Abuse and Neglect</td>
</tr>
<tr>
<td>59G-4.295</td>
<td>Therapeutic Group Care Services Specialized Therapeutic Services Coverage and Limitations Handbook</td>
</tr>
<tr>
<td>59G-4.360</td>
<td>Transplant Services</td>
</tr>
<tr>
<td>59G-13.132</td>
<td>Traumatic Brain and Spinal Cord Injury Waiver Disposable Incontinence Medical Supplies Fee Schedule</td>
</tr>
<tr>
<td>59G-13.130</td>
<td>Traumatic Brain and Spinal Cord Injury Waiver Services</td>
</tr>
<tr>
<td>59G-13.131</td>
<td>Traumatic Brain Injury and Spinal Cord Injury Waiver Services Fee Schedule</td>
</tr>
<tr>
<td>59G-4.340</td>
<td>Visual Aid Services</td>
</tr>
<tr>
<td>59G-4.210</td>
<td>Visual Care Services</td>
</tr>
</tbody>
</table>
INCIDENT REPORT
CONFIDENTIAL — DO NOT COPY. FORWARD TO RISK MANAGEMENT WITHIN 24 HOURS.

Incident: ___ / ___ / ___ Time:_______ AM/PM Date Reported: ___ / ___ / ___ RM Ref No: _________
Line of Business: ___________________________ □ Member □ Employee □ Associate/Agent □ Visitor

Name: ___________________________ DOB: ___ / ___ / ___ Sex: □ Male □ Female
Address: ___________________________ City: ______________ State: ______ Zip: _________
ID No: __________________________ Phone (H): _____________________ Phone (W): _____________________

Name of Provider/Facility Involved in Incident:____________________________________________________
Location of Incident (specify where):

□ Pharmacy: ___________________________________ □ Plan Site: __________________________
□ Physician’s Office: __________________________ □ Member’s Home: _______________________
□ ER/Hospital/OP Facility: _______________________ □ Rehab/SNF: _________________________
□ Transportation: ______________________________ □ Other: _________________________________
Nature of Incident: POTENTIAL CODE 15* and * Serious Adverse Incidents and Sentinel Events

□ Death of patient □ Severe brain or spinal damage □ Surgical procedure performed on wrong patient
□ Surgical procedure unrelated to the patient’s diagnosis or medical needs
□ Quality of Care Issues/Outcomes/near-miss events/med errors _________________________
□ Other: (explain) ___________________________________________________________

PROVIDER/NETWORK RELATED:

□ Breach of Duty/Contract
□ Provider Dispute(s)
□ Access/Availability
□ Anti-Trust
□ External: ___________________________
GENERAL LIABILITY/PROPERTY/CASUALTY:

□ Theft/destruction
□ Property loss
□ Equipment
□ Slip/fall/ injury
□ Other (explain): ___________________________

MEDIA RELATED:

□ Member/family threatens to go to press
□ Bad publicity re: participating provider
□ Bad publicity re: company/employee
□ Media contacted company/employee
□ Other (explain): ___________________________

THREAT TO SUE:

□ Member/family threatens to sue
□ Provider threatens to sue
□ Other (explain): ___________________________

Potential/Actual Fraudulent Activity: ___________________________ Other: ___________________________

INCIDENT REPORT – REVISED DATE 3/12/18
Description of Incident: Narrative of Incident (to include when, where, and what happened):

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Persons Involved and/or all Witnesses

<table>
<thead>
<tr>
<th>Name</th>
<th>Department or Address</th>
<th>Extension or Phone</th>
<th>How is this person involved</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Outcome:  

- [ ] No apparent injury  
- [ ] Apparent injury  
- [ ] Legal/Medical Involved  

If injured, nature of injury: _____________________________

If Applicable:  

ICD10 (1): _____________________________  ICD10 (2): _____________________________

Medication related:  

- [ ] No  
- [ ] YES (explain) _____________________________

Determination (as applicable):

- Physician Intervention:  
  - [ ] Yes  
  - [ ] No  

- Physician Intervention Refused:  
  - [ ] Yes  
  - [ ] No

If physician intervention, provide name, date and time notified:

Physician’s Name: _____________________________  Date: ___/___/___  Time: ___________ AM/PM

Diagnosis: _____________________________  Treatment: _____________________________

Treatment Site:  

- [ ] Physician’s Office  
- [ ] ER  
- [ ] Hospital Admit  
- [ ] Other (identify): _____________________________

If Physician’s Office, treatment and disposition: _____________________________

If ER, treatment and disposition: _____________________________

If hospital admit: Date of Admission: ___/___/___  Time of Admission: __________ AM/PM

Hospital Name: _____________________________  Treatment Plan: _____________________________

Discharge Date: ___/___/___

PRINT NAME OF PERSON REPORTING: _____________________________  DEPT/TITLE: _____________________________

SIGNATURE: _____________________________  DATE: ___/___/___  TIME: _____________________________

LOCATION: _____________________________
Medical Director Review and Analysis:

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Level*: □ 0     □ 1     □ 2     □ 3 (Code 15)

Medical Director’s Signature: __________________________________________ Date: ___ / ___ / ___

RM Activity

□ Code 15 Report     □ Legal Department     □ Medical Director/Peer Review     □ Log/Trend     □ Education
□ Premise/Security Correction     □ Other: ___________________________     □ HR Notification of Employee Incident

RISK MANAGER NOTES:

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Risk Manager’s Signature:_________________________ Name Printed: ___________________ Date: ___ / ___ / ___

Closed date: ___ / ___ / ___ Disposition: ___________________________ Other: ___________________________

* KEY: 0 = no action needed; 1 = Track and Trend; 2 = Corrective Action Required; 3 = Code 15
INCIDENT REPORT: GENERAL INSTRUCTIONS

1. ALL ENTRIES MUST BE CLEAR AND LEGIBLE.
2. DO NOT FILL IN SHADED AREAS.
3. COMPLETE INFORMATION TO THE BEST OF YOUR ABILITY. IF YOU DO NOT KNOW THE INFORMATION LEAVE AREA BLANK.
4. Enter the Date/Time of INCIDENT; Enter Date REPORTED; (do not fill in RM Reference Number.)
5. Line of Business: Identify which plan.
6. Check if the incident relates to an Employee, Member, Agent/Associate or Visitor.
7. Write the person’s full Name, Date of Birth, check if Male or Female
8. If incident occurred with a member, write full ID Number.
9. Write the person’s full address, phone, cell, pager, etc.
10. If incident is Provider or Facility related, write full name and address, include telephone #...
11. Location: Identify WHERE incident occurred.
12. Alleged Nature of Incident: Check where appropriate.
13. Narrative: Provide detailed, to the point, and factual information regarding what occurred.
   a. Describe the circumstances of the incident in narrative form.
   b. Use an additional sheet if necessary rather than crowding your explanation into the space provided.
   c. This is a factual accounting of the incident that includes the specifics of how the incident occurred.
   d. DO NOT editorialize. Personal opinions and subjective information is NOT to be included.
14. Description of Incident. If you know them, add ICD10 (1) and ICD 10 (2) for clinical issues or leave blank.
15. Indicate if it was a Medication Discrepancy or Error.
   a. Provide the facts.
   b. If the incident is a medication or the administering of a medication, provide the name of the drug, dosage, time given, reason and name and license number of person who administered drug, and how the incident occurred.
16. Provide information about any witnesses.
   a. List the persons who were directly involved and/or witnesses to the incident.
   b. Provide name, department, address, telephone, license number and social security number of unlicensed personnel.
17. If the person was a patient in the hospital, answer questions regarding the hospital.
18. Outcome: Check box, clearly describe appearance of injury.
19. Determination: If a Physician was called; check appropriate boxes. Provide as much clinical information as available: Name of physician, date, time, diagnosis, the physical findings, discharge the outcomes, etc.
20. The person completing report needs to indicate their full name, title, department, and extension.
   a. MUST include their Signature/Date/Time of completing report.
21. If you received your supervisor’s assistance, have the supervisor sign the incident report.
22. NOTE: State law precludes any requirement for supervisory approval to submit incident reports and a fine can be imposed by the state for any interference in the submission of an incident report.

23. Medical Director review to be completed by the Medical Director.

24. RM Activity to be completed by the Risk Manager.

25. Forward report to Risk Manager within 24 hours of receipt.

26. Do NOT photocopy or keep a copy.

27. Do NOT state or document in any form that you “completed an Incident Report,” contacted the Risk Manager, and called the legal department or other indication of notifying administration. YOU MAY document only the facts as you find them, i.e. “patient found laying on the floor.”