
Overview

This section of the Provider Manual addresses the respective responsibilities of participating physicians and other providers.

Primary Care Offices

Primary Care Physicians (PCPs) provide comprehensive Primary Care services to Plan members. Primary Care offices participating in the Plan provider network receive the following benefits:

- A potential increase in the number of members through multiple Plan participation in health fairs and marketing campaigns;
- Full support of the Provider Relations, Customer Service, Claims, Health Services and Marketing/Sales teams;
- Information on discharge planning; and
- Access to the medical resources of the participating network of providers, hospitals and ancillary services.

Primary Care Physician Responsibilities

Following is a summary of responsibilities specific to PCPs who render services to Plan members. Please also refer to the listing of responsibilities for “All Physicians.” Additional information may be found in the Provider Agreement.

1. Coordinate, monitor and supervise the delivery of Primary Care services to each member.
2. Ensure the availability of physician services to members in accordance with “Appointment Scheduling” as outlined in this section.
3. Arrange for on-call and after-hours coverage in accordance with the after-hours service as outlined in this section.
4. Ensure members are aware of the availability of public transportation, where available, and the medical non-emergency transportation service

available by calling Customer Service.

5. Maintain a ratio of members to full-time-equivalent (FTE) physicians as follows:
 - One physician FTE per 1,500 Medicaid or Healthy Kids members.
 - One advanced registered nurse practitioner (ARNP) FTE for every 750 Medicaid or Healthy Kids members above 1,500.
 - One physician assistant (PA) for every 750 Medicaid or Healthy Kids members above 1,500.
6. Provide access to the Plan or its designee to examine thoroughly the Primary Care offices, books, records and operations of any related organization or entity. *A related organization or entity* is defined as: having influence, ownership or control and either a financial relationship or a relationship for rendering services to the Primary Care office.
7. Submit an encounter for each visit where the provider sees the member or the member receives a HEDIS[®] (Health Care Effectiveness Data and Information Set) service.
8. Submit encounters on a CMS 1500.
9. Provide immunizations to Healthy Kids members assigned to the Plan.
10. Ensure members utilize network providers. If unable to locate a participating provider for services required, contact Utilization Management for assistance.
11. See members for an initial office visit and assessment within the first 90 days of enrollment in the Plan.
12. Ensure sufficient supply and provide immunizations in accordance with the

Recommended Childhood Immunization Schedule for the United States or when medically necessary for the member's health.

13. Provide immunization information to DCF upon receipt of the member's written permission and DCF's request, for members requesting temporary cash assistance from the DCF in order to document that the member has met the immunization requirements for recipients receiving temporary case assistance.
14. Participate in the Vaccines for Children (VFC) program for Medicaid children 18 years old and younger to help raise childhood immunization rates. Immunizations should be given in conjunction with required CHCUP. The Plan will reimburse providers for the administration of the vaccine but not the vaccine itself as vaccines are supplied to the provider at no charge through the VFC program. Providers must administer only VFC-supplied vaccinations for Medicaid members for all immunizations supplied through the VFC program.
15. Notify patients of certification decisions when received from the Plan.

Domestic Violence and Substance Abuse Screening

Physicians should identify indicators of substance abuse or domestic violence. The screening tools for domestic violence and substance abuse are located in the **Provider and Member Education** section. Should a member need assistance regarding Domestic Violence, the PCP should direct the member to contact Customer Service and ask to speak with the Case Management department.

Smoking Cessation

Physicians influence the decisions members make about their health care. The Plan offers a smoking cessation program that will help members break both the physical and psychological addiction to cigarettes.

PCPs should direct members who smoke or desire to

quit smoking to call Customer Service and ask to speak with the Case Management department. A case manager will educate the member on national and community resources that offer assistance, as well as the options available to the member by WellCare. All members who call will receive educational material including “Just Quit,” a tobacco cessation program guide. Additionally, the Plan can assist OB providers when they identify pregnant members who are at risk as a result of smoking. Case managers can provide information and names of support groups available through Healthy Start and the local health departments.

Also available to physicians through Provider Relations is “Treating Tobacco Use and Dependence,” a **Quick Reference Guide** from the Public Health Service Clinical Practice Guidelines. Please contact a local Provider Relations representative to request a copy. More information on smoking cessation is located in the **Provider and Member Education** section of this manual.

Adult Health Screening

An adult health screening should be performed by a physician to assess the health status of a member age 21 or older. The adult member should receive an appropriate assessment and intervention as indicated or upon request. Please refer to the screening tools in the **Provider and Member Education** section of this manual.

Child Health Check-Ups

Well-Child/CHCUP (Child Health Check-up) is a Medicaid child health program of early and periodic screening, diagnosis and treatment services for beneficiaries under the age of 21. **All children of these ages who are WellCare/HealthEase members should receive an exam.** It supports two goals: to ensure access to necessary health resources and to assist parents and guardians in appropriately using those resources.

Well-Child/CHCUP Components

The screening component of the CHCUP includes a general health screening most commonly known as a

periodic well child exam. The required CHCUP screening guidelines are based on the American Academy of Pediatrics' recommendations for preventive pediatric health care include:

- Comprehensive health and developmental history
- Developmental/behavioral assessment
- Age-appropriate unclothed physical examination
- Height and weight measurements and age-appropriate head circumference
- Blood pressure for children 3 and older
- Immunization review and administration of appropriate immunizations
- Health education including anticipatory guidance
- Nutritional assessment
- Hearing, vision and dental assessment
- Blood lead level testing for children younger than six years of age
- Interpretive conference and appropriate counseling for parents or guardians
- Objective testing for developmental behavior, hearing and vision must be performed in accordance with the Medicaid periodicity schedule
- Laboratory services as appropriate

(See the Medical Records section – Pediatric Health Screening for detailed requirements and/or the Medicaid Child Health Check-Up Services Coverage and Limitation Handbook)

WellCare requires providers to use the age-appropriate CHCUP forms, which can be located in the *Forms* section of this manual.

CHCUP Exam Frequency

The recommended schedule for Well-Child exams is as follows:

- Birth (2 weeks)
- 1 month
- 2 months

- 4 months
- 6 months
- 9 months
- 12 months
- 15 months (must occur on or before the 15th month birthday to count as a well-child visit)
- 18 months
- 24 months
- Annually after age 2 through age 21

Primary-Care Providers (PCPs) receive a list of eligible members at the beginning of each month who have chosen or been assigned to the PCP as of that date. Those members in need of a CHCUP are noted on the membership roster and the monthly non-compliant member list. It is the responsibility of the provider to contact members and encourage the member to be seen for the CHCUP.

CHCUP/Well-Child Codes

Exams should be coded on claim forms using CPT codes 99381 through 99395, whichever is applicable for new patients, as indicated in the following chart. Correct codes are required for timely and accurate claims payment and documentation of services provided.

New Patient/Initial Exam

CPT Code	Description
99381	Infant (age under 1 year)
99382	Early Childhood (1-4 years of age)
99383	Late Childhood (5-11 years of age)
99384	Adolescent (12-17 years of age)
99385	18 -20 years of age

Established Patient/Periodic Exam

CPT Code	Description
99391	Infant (age under 1 year)
99392	Early Childhood (1-4 years of age)
99393	Late Childhood (5-11 years of age)
99394	Adolescent (12-17 years of age)
99395	18 -20 years of age

These codes should be used along with appropriate

ICD-9 diagnosis codes (V20.2, V70.0, V70.3, V70.5, V70.6, V70.8 or V70.9 codes). When updating routine CHCUP status at the time of an acute care visit, the next-higher level E&M CPT code may be submitted if the appropriate ICD-9 code is also submitted as a secondary diagnosis.

Referrals

If the PCP is unable to provide all the components of the Well-Child/CHCUP exam or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider in accordance with WellCare's referral procedures. The member's medical record must indicate where the member was referred.

Blood Lead Level Testing

The Centers for Medicaid and Medicare Services (CMS) and the State of Florida Medicaid Program requires that all children be blood lead tested at 12 months and again at 24 months of age, or between 36 and 72 months of age if not previously tested. Filter paper testing is an accepted method to obtain blood lead levels and is covered by WellCare.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during the Well-Child/CHCUP exam as needed. WellCare endorses the same recommended childhood immunization schedule that is recommended by the Center for Disease Control and approved by the American Academy of Pediatrics.

WellCare encourages all providers to participate in the Florida Shots program.

**Members
With Special
Health Care
Needs**

Members with special needs are defined as adults, children and adolescents who face physical, mental or environmental challenges daily that place at risk their health and ability to fully function in society. They include, for example, members with mental retardation or related conditions; members with serious chronic illnesses such as HIV, schizophrenia or degenerative

neurological disorders; members with disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes; and adults, children and adolescents with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

The following is a summary of responsibilities specific to physicians who render services to Plan members identified as having special health care needs:

- Assess the member and develop a plan of care for those members determined to need a course of treatment or regular care;
- Coordinate treatment plan with member, family and/or specialist caring for member;
- Plan of care should adhere to community standards and any applicable agency quality assurance and utilization review standards;
- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the member's condition or needs.
- Coordinate with the Plan, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member;
 - Members may request a specialist as PCP through the Customer Service department or their case manager. If the medical director agrees the specialist is appropriate as a PCP and the specialist agrees to act as the PCP, the member will be assigned to that specialist by the Customer Service department.

- Coordinate services with other managed care organizations to prevent duplication of services and share results of its identification and assessment of the member's needs; and
- Ensure the member's privacy is protected as appropriate during the coordination process.

Member Rights and Responsibilities

Plan members (enrollees) have specific Rights and Responsibilities. These must be posted in your office for all members to see.

Please note that members have the right to:

- Be treated with respect and with due consideration for their dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Participate in decisions regarding their health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of their medical records, and request that they be amended or corrected. (Requests must be received in writing from you or the person you choose to represent you. The records will be provided at no cost. They will be sent within 14 days of receipt of the request.)
- Be furnished health care services in accordance with federal and state regulations.

The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

Contact a Provider Relations representative for a copy of the Patient Rights and Responsibilities document.

Living Will and Advance Directive

Members have the right to control decisions relating to their medical care; including the decision to have

withheld or taken away the medical or surgical means or procedures to prolong their life. The law provides that each Plan member (age 18 years or older of sound mind) should receive information concerning this provision and have the opportunity to sign an Advance Directive Acknowledgement Form to make their decisions known in advance. This allows members to designate another person to make a decision should they become mentally or physically unable to do so.

Advance Directive forms should be made available in provider's offices and discussion with the member as well as the completed forms should be documented and filed in the member's medical record. A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

Closing of Physician Panel

When closing their panel to new and transferring Plan members, PCPs must:

- Submit the request in writing at least 60 days prior to the effective date of closing his or her panel;
- Maintain his or her panel open to all Plan members who were provided services prior to the closing of his or her panel; and
- Submit written notice of the re-opening of his or her panel including a specific effective date.

Additionally, when reviewing the panel size of the PCP, the Plan reserves the right to close the PCP's panel if the PCP has more than 1,500 members assigned and does not have additional PCPs or mid-level practitioners (PA or ARNP) to treat members.

Out-of-Area Member Transfers

Participating physicians and providers should assist the Plan in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by the Plan physician and/or the provider and out-of-network attending physician.

**PCP Request
for Transfer
of a Member**

A Plan physician or provider may not seek or request to terminate their relationship with a member or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required or the cost of covered services required by the Plan's member. Membership acceptance must be without regard to color, gender, race, religious belief, national origin or handicap of applicant.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. The physician or provider should provide adequate documentation in the member's medical record to support his or her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider or physician shall continue to provide medical care for to the Plan member. Care shall continue until such time that written notification is received from the Plan stating that the member has been transferred from the provider or physician's practice.

In the event a participating physician or provider desires to terminate their relationship with a Plan member, the physician or provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory provider and member relationship, the member's non-compliance with treatment or uncooperative behavior, is impairing the ability to care for and treat the member effectively.

The physician or provider completes a PCP Request for Transfer of Member form, attaching supporting documentation, and faxes the form to the Customer Service department at the fax number listed on the form. A copy of the form is available in the **Forms** section of this manual.

Vacations

PCPs should notify the Plan, in writing, of the vacation time scheduled along with information regarding the

provisions made for coverage during the PCP's absence. The provider covering for the PCP must be an active, credentialed Plan provider.

**Responsibilities
of All Physicians**

The remainder of this section of the Manual is an overview of responsibilities for which all Plan providers are accountable. Please refer to the Provider Agreement or contact a Provider Relations representative for clarification of any of the following.

Physicians must, in accordance with generally accepted professional standards:

1. Use physician extenders appropriately. Physician assistants (PA) and advanced registered nurse practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the state of Florida and Plan guidelines.
2. Assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations.
3. Clearly identify their titles, such as ARNPs and PAs, to members as well as to other health care professionals.
4. Honor at all times any member request to be seen by a physician, rather than a physician extender.
5. Accept treatment for any member in need of health care services they provide.
6. Refer Plan members with problems outside of his or her normal scope of practice for consultation and/or care to appropriate specialists contracted with Plan.
7. Refer members to participating physicians or providers, except when they are not available

- or in an emergency.
8. Admit members only to participating hospitals, SNFs and other inpatient care facilities, except in an emergency.
 9. Respond promptly to Plan requests for medical records in order to comply with regulatory requirements.
 10. Inform Plan in writing within 24 hours of any revocation or suspension of his or her Bureau of Narcotics and Dangerous Drugs number, and/or suspension, limitation or revocation of his or her license, certification or other legal credential authorizing him/her to practice in the state of Florida.
 11. Inform Plan in writing immediately of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his or her status with Plan.
 12. Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Plan member, subscriber, or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a “fee-for-service” basis. Non-covered services are services not covered in the member’s Plan contract.
 13. Treat all member records and information confidentially, and do not release such information without the written consent of the member, except as indicated herein, as allowed or needed for compliance with state and federal law.
 14. Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.

15. Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in the Plan's Quality Improvement Guidelines. All entries in the member record must identify the date and the provider.
16. Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.
17. Utilize either disposable equipment or proper sterilization methods for instruments used to perform procedures.
18. Ensure the office staff is trained on the proper use of safety, emergency and fire-extinguishing equipment.
19. Maintain a comprehensive emergency and evacuation plan on which all office personnel is instructed. The plan should include a provision for the safe evacuation of patients from the premises, particularly those lacking mobility. The emergency plan should also address techniques for cardiopulmonary resuscitation (for organizations where it is appropriate) that are formally reviewed with the office staff four times per year. Documentation of such resuscitation drills should be available for at least one of the four performed per year.
20. Have emergency medications on hand (i.e., Epi-pen and ambue bag at a minimum) in case an emergency occurs while a member is in the office.
21. Communicate clinical information between Plan providers timely. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to the Plan, the member or the requesting party, at no charge, unless

otherwise agreed upon.

22. 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.
23. Not discriminate in any manner between Plan members and non-Plan members.
24. Fully disclose to members their treatment options and allow them to be involved in treatment planning.
25. Inform member of specific health care needs which require follow-up and provide, as appropriate, training in self-care and other measures members may take to promote their own health.
26. Encourage members to utilize the Personal Health Advisor Line (Plan's telephone-based triage program) for free-telephonic, medical advice 24 hours a day, 7 days a week. It is a service that a member may use before calling the PCP. After the assessment, the Health Advisor may suggest that the member perform self-care, call or make an appointment with the PCP, go to an urgent care center or to an emergency room. Please refer to the **Quick Reference Guide** for the telephone number for the Plan's Personal Health Advisor.
27. Identify members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal or postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to plan-sponsored or community-based programs.

The provider must document the referral to plan-sponsored or community-based programs in the

member's medical record and provide the appropriate follow-up to ensure the member received the services needed.

WellCare is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating provider of the health plan and that the provider's submission of encounter data is accepted by the Florida MMIS and/or the state's encounter data warehouse.

Specialist Responsibilities

Specialists are responsible for treating Plan members referred to them by the PCP and communicating with the Plan's Health Services department for authorizations. Specialists may not refer to another Plan specialist. Authorizations for Medicare members must be coordinated through the member's PCP.

Confidentiality of Member Information and Release of Records

All consultations or discussions involving the member, or his or her case, should be conducted discreetly and professionally in accordance with all applicable state and federal laws including the HIPAA Privacy and Security regulations.

All physician practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure that there is: (i) a privacy officer on staff; (ii) a policy and procedure in place for confidentiality of members' Protected Health Information; and (iii) that the practice is following those procedures and/or obtaining appropriate authorization forms from members to release Protected Health Information as required by applicable state and federal law.

Policies and procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information to include Protected Health Information.

All members have a right to confidentiality, and any health care professional or individual person who deals

directly or indirectly with the member or his or her medical record must honor this right.

Every practice is required to provide to members their Notice of Privacy Practice. Employees who have access to member records and other confidential information are required to sign a confidentiality statement.

Some examples of confidential information includes:

- Any communication between a member and a physician;
- All Protected Health Information as defined under the federal HIPAA Privacy regulations;
- Any communication with other clinical persons involved in the member's health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security number, etc.);
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem;
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
- Any communicable disease (such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

When an individual enrolls in the Plan, federal law permits the health care provider permission to release his or her medical records to WellCare, members of the provider network or agencies conducting regulatory or accreditation reviews and business associates.

The Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or health plan may use or

disclose the members' protected health information (PHI). HIPAA regulations require each provider and health plan to provide an NPP to each new patient or member accordingly.

Appointment Scheduling

Providers must adhere to the following criteria to comply with state and/or federal availability and access standards:

1. Primary Care Providers:

- Provide medical coverage 24 hours a day, seven days a week.
- Schedule and see emergent referral appointments immediately.
- Schedule and see urgent referral appointments within one day.
- Schedule and see routine "sick" patient care appointments within one week.
- Schedule and see "well" care visits within one month of a member request.
- See scheduled appointments within 30 minutes of the appointment time.

Florida Healthy Kids Primary Care Providers:

- Provide medical coverage 24 hours a day, seven days a week.
- Schedule and see emergent referral appointments immediately.
Schedule and see "urgently needed" care appointments within 24 hours.
- Schedule and see routine care appointments of enrollees who do not require emergency or urgent care within seven calendar days.

- Schedule and see routine physical examinations within four weeks.
- See scheduled appointments within 30 minutes of the appointment time.

2. Specialty Care Providers:

- Schedule “well” care visits within 30 days of a member request.

After-Hours Services

The PCP must be available after regular office hours to offer advice and to assess any condition that might require immediate care. This includes referral to the nearest hospital emergency room in the event of a serious illness.

To ensure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service that will page the physician after a message is left.
- Answering system with option to page the physician.
- An advice nurse with access to the PCP or on-call physician; or
- Answering system that will provide a number to access physician or live answering service.

Covering Physicians

In the event that participating providers are temporarily unavailable to provide care or referral services to Plan members, providers should make arrangements with another Plan-contracted and credentialed physician to provide services on their behalf, unless there is an emergency.

In non-emergency cases, should you have a covering physician who is not contracted and credentialed with the Plan, contact the Plan for approval. The physician should be credentialed by the Plan, must sign an

agreement accepting the negotiated rate and agree not to balance bill Plan members. For additional information, please contact the local Provider Relations department.

Provider Billing and Address Changes

Prior notice to the Plan is required for any of the following changes:

- 1099 Mailing Address
- Tax Identification Number or Entity Affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and/or fax number

Provider Termination

In addition to the provider termination information included in your Provider Agreement with the Plan, the provider must adhere to the following terms:

- Any contracted provider must ensure at least **60 days prior written** notice for Medicare and **90 days prior written** notice for Medicaid before the “without cause” termination of a contracted provider’s participation. Please refer to your contract for the details regarding the specific required days for providing termination notice.
- Unless otherwise provided in the termination notice, terminations occur on the last day of the month. For example: Required notice in 60 days. A termination letter is dated October 15. The required notice is 60 days. Termination is therefore effective December 31.
- Providers are entitled to a dispute resolution mechanism, also sometimes referred to as an appeal, to resolve disputes that relate to the providers' status with the Plan (e.g., termination or suspension) and any action by the Plan related to the provider's

competency or conduct (e.g. clinical or quality of care issues). The **Credentialing Section** of this Provider Manual sets forth the Plan's Participating Provider Dispute Resolution Peer Review Panel process, which is made available to providers whose condition of participation with the Plan is altered based on issues of quality of care, conduct or service, and that when such process is implemented may require reporting to regulatory agencies. A dispute resolution process (e.g., arbitration) for providers for non-clinical performance functions is set forth in provider participation agreement, and in the case of providers who are physicians who are terminated from the Plan may also include an appeal.

Note: The Plan must notify all appropriate agencies and/or members in writing of a provider termination as required by regulations and statutes.

Provider Incident Reporting Requirements

In the event of an adverse or untoward incident, defined as a Code 15 case by the Agency for Health Care Administration (AHCA), whether occurring in a facility of one of the Plan's providers or arising from health care prior to admission to a facility that occurs to a Plan member which may result in:

- The death of a member
- Fetal death
- Severe brain or spinal damage to a member
- A surgical procedure being performed on the wrong member/wrong site
- A surgical procedure unrelated to the member's diagnosis or medical needs being performed on a member
- Surgical procedure to remove foreign objects remaining from a surgical procedure

- Surgical repair of injuries from a planned surgical procedure

This incident must be reported to the Plan's Quality Improvement department on the Incident Report form located in the **Forms** section of this manual.

Reporting Unusual Incidents on Provider's Premises

Unusual incidents that occur on the property of the provider should be reported to the designated risk manager at that location. The following are examples:

In the event of an incident/injury to a member or visitor at a Plan participating provider:

- Report occurrence to office administrator or risk management contact person in their office immediately.
- If injury has occurred, obtain immediate medical assistance for visitor by physician or offer ambulance transportation to nearest contracted Emergency Room.
- Medical record will be complete and documented in compliance with the Plan's medical record keeping as for any other member.

In the event a patient or visitor becomes abusive (physically or verbally) at the Plan's participating provider premises:

- Report occurrence to office administrator or risk management contact person in their office immediately. Attempt to calm patient or visitor (do not argue or disagree with abusive individual).
- Notify police if patient/visitor is physically threatening.
- Remove other patients or visitors from the immediate area.

- Do not attempt to restrain abusive individual unless another person is placed in danger. If restraint must be used, every effort must be made to keep the abusive person from physical harm (it is recommended that two individuals be present to assist an abusive individual).
- In the event the abusive individual is a member, the attending physician should also be notified immediately.
- The participating provider's office notifies the Plan's Customer Service department of the incident, if appropriate.

Other incidences that are required to be communicated to the Plan include: a slip or fall by a patient or family member, medication error, reaction requiring treatment, abusive patient or family member, a theft or loss from provider's office, malfunction or damage of equipment during treatment, accusations of malpractice by a patient or family member or non-compliance with potential to be life-threatening.

An Incident Report form, included in the **Forms** section of this manual, should be used to report all incidents to the Plan's risk manager.

Further reporting to the Plan's insurance carrier and governmental agencies, as appropriate, shall be arranged within the prescribed time frames by the Plan's risk manager. Physicians are reminded that serious negative events or incidences which occur in a provider's office or facility must be reported to AHCA directly by the provider.

Marketing and Sales

In general, providers should only market in their capacity as a participating provider of the Plan's network and only in coordination with the specific guidelines concerning provider marketing. Providers should contact the Plan's Marketing and Sales department to discuss and coordinate permissible provider marketing activities.

All marketing materials describing the Plan organization in any way must first obtain the prior written approval of the Plan and include the Plan's name and/or logo as well as the provider's name and/or logo. These materials must adhere to the guidelines and approval of the Plan, CMS and AHCA as appropriate. Providers should contact the Plan's Marketing and Sales department to coordinate permissible provider marketing activities.

Community Outreach Requirements

Providers must adhere to specific requirements regarding community outreach.

- Health care providers may display Plan-specific materials in their own offices.
- Health care providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network.
- Health care providers may announce a new affiliation with a health plan and give their patients a list of health plans with which they contract.
- Health care providers may co-sponsor events such as health fairs and advertise with the Plan in indirect ways; such as television, radio, posters, fliers, and print advertisement.
- Health care providers shall not furnish lists of their Medicaid patients to the Plan or any other entity, nor can providers furnish other health plans' membership lists to the Plan, nor can providers assist with Plan enrollment.
- For the Plan, health care providers may distribute information about non-health-plan-specific health care services and the provision of health, welfare and social services by the State of Florida or local communities as long as any inquiries from prospective enrollees are referred to the member

services section of the Plan or the Agency's choice counselor/enrollment broker.

Disclosure of Information

Periodically, members may inquire as to the operational and financial nature of their health plan. In accordance with federal and state disclosure requirements, the Plan will provide that information to the member upon request. Members can request the above information verbally or in writing. For more information about how to request this information, members should contact Plan's Customer Service department. The toll-free telephone number can be found on the member's ID card.

Delegated Entities

All participating providers or entities delegated for Network Management and Network Development should meet all applicable standards are held to the same standards as defined in this section. Reviews are performed and compliance is monitored on a regular basis.