TITLE 21

Miami-Dade
Marathon
Ft. Lauderdale
West Palm Beach
Ft. Pierce
Sarasota
Ft. Myers
Naples

PROVIDER MANUAL

Community Care Plan

1643 Harrison Parkway, Suite H200, Sunrise, FL 33323

❖ Telephone: 866-202-1132 ❖

WELCOME

We are pleased to welcome you as a network provider in the CMSN South, Southeast and Southwest Florida Regions. The CMSN - SFCCN is a partnership formed by the South Florida Community Care Network (SFCCN) and the Department of Health's Children's Medical Services. The South Florida Community Care Network consists of two governmental entities: South Broward Hospital District (SBHD) and the North Broward Hospital District (NBHD).

As an Integrated Care System (ICS), the CMSN - SFCCN will provide medical services to eligible Florida KidCare recipients. You have chosen to become a provider of this very unique network. Together we will work with you as a team, bringing our individual expertise to achieve the high standards our community expects. We will endeavor to provide quality coordinated care to the children with special health care needs covered under Title XXI (KidCare).

You have committed to delivering quality medical care to CMSN - SFCCN enrollees. This provider manual answers many of your questions about the ICS and how it works. Outlined in your Provider Manual are the policies, procedures, and programs you have agreed to comply with, as presented in the Provider Services Agreement between you and the CMSN - SFCCN. We are requesting your expertise to ensure that the care provided to the enrollees meets the performance indicators as outlined in your manual. Please review this material to better understand the importance of your role in the provision of services to CMSN - SFCCN enrollees and compliance with designated program requirements.

Should you have any questions or wish further information about the program or policies contained in the manual and you are a provider practicing in Miami, Marathon, Ft. Lauderdale, West Palm Beach, Ft. Pierce, Sarasota, Ft. Myers or Naples, we urge you to call the SFCCN Provider Relations Department below. Please note that this manual and its contents are subject to change. We will make every effort to inform you of significant changes in our policies and procedures.

You are a key part in the Children's Medical Services Integrated Care System (ICS). We look forward to a mutually satisfying relationship.

Sincerely,

Provider Relations
CMSN - Florida Region
1 (855) 819-9506

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PROVISION OF SERVICES

CMS covered services for enrollees shadow the benefits and limitations within the State of Florida Medicaid program (refer to the Medicaid Coverage, Limitations and Reimbursement Handbooks for specific information). These handbooks may be ordered from the Medicaid fiscal agent or can be accessed on the AHCA website.

CMS covered services include:

- Health Assessment Screening – including hearing, vision and dental screenings
- Physical Exams: Routine and chronic disease check-ups
- Well Child Care and Immunizations – health and development history & updating of routine immunizations as well as referrals for further diagnosis and treatment when necessary
- Lab and X-ray Services
- Physical Therapy and Respiratory Therapy Services
- Home Health Services
- Durable Medical Equipment

Maternity Care:
All pregnant enrollees will be offered a choice of a participating obstetrical doctor or nurse midwife for prenatal care and delivery of the newborn. All women of childbearing age will be provided counseling, testing, and treatment of blood-borne diseases that may affect them or their unborn child.

Emergency Care:
Emergency Services are those necessary to treat a condition, illness, or injury threatening life or limb which requires immediate attention.

Hospital Inpatient Care:
Includes all inpatient services authorized by the CMSN - SFCCN: room and board, nursing care, medical supplies, diagnostic and therapeutic services. There is **no** annual forty-five (45) day cap on inpatient care, pursuant to the Medicaid Benefits for children under 19 years of age.

Hospital Outpatient Care:
Includes all diagnostic and therapeutic services provided as an outpatient at a participating hospital or outpatient facility by a participating specialist. There is **no** annual cap on outpatient services pursuant to Medicaid Benefits for children under 19 years of age.

Hearing Services:
Includes hearing evaluation, diagnostic testing and fitting of one hearing aid per year.

Transportation:
If a parent is unable to transport their child to his/her medical appointment, they can call **LogistiCare** to schedule transportation. This service is only available when no other transportation is available (no family, friend or other form of transportation is accessible). **To make a reservation for transportation**, please call **LogistiCare** at 1-866-429-8529.

If you need assistance with an existing reservation, please call **LogistiCare** at 1-866-429-8861.

Behavioral Health:
For mental health and substance abuse services, the current Medicaid benefits apply. University of Miami Behavioral Health (CONCORDIA) will provide the behavioral health services. To coordinate behavioral health services, please contact CONCORDIA at:

1-800-294-8642

Vision Care:
Includes eye examinations by a certified participating optometrist necessary for fitting of glasses (one eye exam and one pair of glasses per enrollee per year) or contact lenses when medically necessary and follow-up examinations.

Family Planning: (**NOTE:** see guidelines for under the age of 19)

- Informational and referral
- Education and counseling
- Diagnostic testing
- Contraceptives
- Follow-up care to assist with spacing births
- Assistance in determining problems related to infertility
- Medically necessary sterilization

Pharmacy Services
Prescription drugs are administered by MedImpact, the pharmacy benefit management company for CMS. Pharmacy locator and formulary lookup can be accessed at http://www.doh.state.fl.us/cms/PharmBM/html. Questions regarding the formulary or drug exceptions should be directed to the CMS Nurse Care Coordinators. Requests can be made through the CMS Nurse Care Coordinator at the following number:

Miami-Dade	1-866-831-9017
Marathon	1-800-342-1898
Ft. Lauderdale	1-800-204-2182
West Palm Beach	1-877-822-5203
Naples	1-239-552-7400
Ft. Myers	1-800-226-3290
Sarasota	1-800-235-9717
Ft. Pierce	1-800-226-1354

CMSN - SFCCN Enrollees will have access to pharmacy, dental services and skilled nursing facilities through the CMS program offices directly. These services are neither managed nor the financial responsibility of the CMSN - SFCCN. Requests can be made through the CMS Nurse Care Coordinator at the following numbers:

Miami-Dade	1-866-831-9017
Marathon	1-800-342-1898
Ft. Lauderdale	1-800-204-2182
West Palm Beach	1-877-822-5203
Naples	1-239-552-7400
Ft. Myers	1-800-226-3290
Sarasota	1-800-235-9717
Ft. Pierce	1-800-226-1354

Scope of Services Benefit Package

- Birthing Center
- Child Health Check-up
- Child Hearing
- Child Vision
- Chiropractic Services
- Clinic Services
- Dental
- Durable Medical Equipment
- Family Planning
- Federal Qualified Health Center (FQHC)
- Home Health Services
- Hospice
- Hospital Inpatient
- Hospital Outpatient
- Lab and X-ray
- Nurse Practitioner
- Occupational Therapy
- Personal Care Services
- Physical Therapy
- Physician Assistant Service
- Physician Services
- Portable X-ray Services
- Prescribed Pediatric Extended Care Services (PPEC)
- Private Duty Nursing
- Respiratory Therapy
- Rural Health Services
- School Based Services
- Speech Therapy

SERVICE DEPARTMENTS

ENROLLEE SERVICES

The primary responsibility of the Enrollee Services Department is to facilitate and guide enrollees in accessing health care service and information about the CMSN - SFCCN. The focus will be the following:

- Orient and educate new enrollees about the ICS
- Determine and answer eligibility questions
- Provide information on covered and non-covered services
- Educate enrollees on CMSN - SFCCN processes and services
- Provide referral/authorization status
- Provide enrollment status
- Direct enrollees to appropriate departments/resources
- Facilitate enrollee access to services
- Receive/investigate/resolve and document complaints
- Analyze/trend complaints for improvement
- Log grievances received and forward to Grievance Coordinator
- Use enrollee feedback to improve quality of services and customer satisfaction
- Eligibility verification

If for any reason an enrollee becomes dissatisfied with the assigned primary care provider, services, and/or location, the enrollee may request a re-assignment at any time by notifying Enrollee Services. The effective date of the change will depend on the day of the month the change is received but generally it will be the first day of the following month.

PROVIDER RELATIONS

The Provider Relations Department is responsible to assist your office with the procedures required by the CMSN – SFCCN. These would include, but are not limited to: new provider orientation, assistance with reporting requirements, educational overviews on CMSN - SFCCN compliance issues, on-site support, assistance with address & other practice changes, questions regarding: procedures, policies, reimbursement, and other program information.

Provider Relations Representatives from the department conduct routine visits of our provider sites. During their visit, the Provider Relations Representatives assess the practice's total compliance with various regulatory and program standards, including: access to care; physical accessibility to practice; medical records keeping practices; patient confidentiality procedures; physical appearance & adequacy of facility; appropriate staffing (medical and administrative); OSHA compliance; grievance procedures; and peer review procedures.

Please contact your Provider Services Representative at 1 (855) 819-9506.

PROVIDER RESPONSIBILITIES

ENROLLEE ID CARDS

Each CMSN - SFCCN enrollee enrolled in Title XXI will receive a CMSN - SFCCN identification card **(see attached example)**, which has valuable information on both sides. Enrollees have been asked to carry their ID card at all times. The CMSN - SFCCN card provides additional information to providers, including:

- The name and phone number of the primary care provider or clinic to which the enrollee is assigned.
- Phone numbers for authorization of services and hospital admissions.

VERIFICATION OF ENROLLMENT

All providers are required to verify eligibility prior to services being rendered. Eligibility needs to be verified even if a provider has a referral and authorization number. This can be done through MED3000:

MED3000 Customer Service: 1-800-664-0146
http://cms.einfosource.med3000.com

RESPONSIBILITIES - ALL NETWORK PROVIDERS

All network providers, through the terms of their participation agreement, are required to comply with CMSN - SFCCN programs, maintain adequate business and confidential medical records, arrange for appropriate coverage, and to comply with the CMSN - SFCCN's access to care standards, which are described in the Quality Improvement section of this manual. Following is a summary of the requirements applicable to all CMSN - SFCCN network providers. For complete information regarding provider responsibilities, please refer to your individual participation agreements.

Confidentiality
All network providers are required to maintain the confidentiality of an Enrollee's information and medical records as required by Federal and Florida law.

Cooperation with CMSN – SFCCN Programs
All network providers are required to comply with the CMSN - SFCCN's Medical Management procedures; Health Management activities; Credentialing Process; Quality Improvement programs (including medical record audits & peer review activities); Claims & Reimbursement guidelines; Grievance procedures; and Incident Reporting guidelines.

Demographic & Status Changes
It is imperative that network providers notify your Provider Relations representative of changes in your practice, prior to the effective date of this change. This information is essential for Provider Directory revisions and ensures continuity of care to the enrollee. Demographic information includes your office address;

telephone number; fax number; e-mail address; tax identification number; and billing address. Status information includes physicians joining/leaving your practice; and the opening or closure of additional practice sites.

Facilities & Environment
All network providers must maintain a safe and sanitary environment for their patients and staff that are in compliance with state and local building codes, federal regulations and work safety requirements. Contracted providers should provide periodic instruction of all personnel in the proper use of safety and fire-extinguishing equipment. Since emergency situations occur with little or no notice, the CMSN - SFCCN encourages providers to develop an Emergency Situation Management Plan to prepare their offices for any disaster.

Cultural and Linguistic Awareness
All providers are expected to be aware of the cultural backgrounds of the patients they serve and to be sensitive toward issues of cultural diversity and health literacy. Providers should post clear, multi-lingual signs in the reception area about the availability of linguistic services and services for the hearing impaired. Providers should also make sure the information used for health education reflects the cultural background and the average literacy of their patient population. Staff training should include information about cultural diversity, the importance of non-verbal communication in patient care, and identifying and addressing patients with health literacy issues. Providers should also ask each patient about their language preference and include the information in their medical record.

PCP RESPONSIBILITIES

New Enrollee Processing
PCPs will receive from the ICS a hard copy CMSN - SFCCN enrollment report specific to his/her patient panel.

To encourage enrollees to visit their PCP, the CMSN - SFCCN Enrollee Services Department will contact each new enrollee by mail through an introductory letter that includes the name and phone number of the enrollee's PCP along with an enrollee ID card. The letter requests the enrollee make an appointment with his/her PCP for initial assessment. Also included will be additional information regarding CMSN - SFCCN benefits.

In addition to the contact by the CMSN - SFCCN, PCPs should welcome their new CMSN - SFCCN enrollees and arrange for an evaluation visit as soon as possible but within the first thirty- (30) days. The enrollee would have received in his/her eligibility/enrollment process from the CMS office, a health assessment form that is completed at the time of enrollment. Once completed, the CMS Nurse Care Coordinator will review it to identify any special health care need for the enrollee to be followed by the CMS Nurse Care Coordinator. A copy of the original form with valuable information will then be forwarded to you for review, action, and final placement in the enrollee's medical records. If you have not already initiated a medical record for the enrollee, this is the opportunity. Be sure to document any attempts to reach the enrollee in the enrollee's medical record.

At the first visit, enrollees should be requested to authorize the release of their medical records. Once received by you, you should identify those children who have

received past screenings (Child Health Check-ups or EPSDTs) according to the Children's Medical Services/Department of Health approved schedules. This facilitates continuity of medical care by having knowledge of the enrollee's past medical history and treatment.

Non-Compliant Enrollees

PCPs have a responsibility to respond to enrollees who either fail to keep appointments or fail to follow a provider's plan of care as either can interrupt continuity of care and lead to a delay or failure on the part of the enrollee to get medical diagnosis or treatment. The CMSN - SFCCN expects providers/provider sites to have a procedure for dealing with non-compliant enrollees and enrollee notification. While it is the enrollee's responsibility to keep appointments and to comply with the plan of care prescribed by the attending physician, the provider in turn has responsibilities when this does not occur. The enrollee needs to be notified of his/her non-compliance and the provider needs to document this activity in the enrollee's medical record whether done orally or in writing. Both the CMSN - SFCCN and CMS/DOH will be monitoring this activity.

"Failure to show" is defined as an enrollee who has missed three (3) consecutive appointments with the same health care provider or facility and does not notify the health care provider that he/she is unable to keep the scheduled appointment. Notification of the assigned CMS Nurse Care Coordinator for "no show" or "failure to show" patients may allow the CMS Nurse Care Coordinator to assist with transportation issues, etc. to prevent future failures to keep appointments.

"Failure to follow plan of care" is when an enrollee chooses not to comply with the prescribed plan of care.

Providers need to make a reasonable effort to establish and maintain a satisfactory relationship with enrollees. The CMS Nurse Care Coordinator can play a major role in assisting the enrollee in compliance.

Removing an Enrollee from Panel (Termination for Cause)

When such a relationship cannot be established or a breakdown occurs, the PCP has the right to request to have the non-compliant enrollee removed from his or her panel. Such a request needs to be communicated to your CMSN - SFCCN Provider Services representative. Each case will be evaluated individually to ascertain if a change in PCP is an option or there is a need for the CMSN - SFCCN to initiate an involuntary termination request from the CMSN - SFCCN through CMS offices-Tallahassee. This latter action by the ICS requires substantial reason and record keeping by the provider to justify the involuntary disenrollment. After ample notification by the provider, if the enrollee fails to correct the situation the PCP should notify by certified mail, the enrollee and CMSN - SFCCN's Provider Relations Department of his/her request to terminate his/her relationship with the enrollee as the PCP. The PCP must continue providing care until the effective date of the change. The PCP should instruct the enrollee to seek assistance from the CMSN - SFCCN's Enrollee Services Department at 866-202-1132.

Requests to Close Panel

Primary Care Providers need to submit to the CMSN - SFCCN in writing any requests to close their panel or to not accept new enrollees. This letter needs to

include the reason for closing their panel and an estimated time frame for non-acceptance of enrollees.

BILLING & PAYMENT FOR SERVICES

PAYMENT FOR SERVICES
MED3000, CMSN's Third Party Administrator, will pay claims within thirty (30) days of receipt of a clean, complete and accurate claim.

BILLING PROHIBITIONS
Provider shall accept payment made by the CMSN - SFCCN in accordance with the terms and conditions of the Provider Services Agreement, as payment in full and accept no payment from CMS enrollees, the enrollee's relatives or any other person or persons in charge as the enrollee's designated representative, in excess of the reimbursement rate made by the ICS/CMS/DOH.

In no event, including, but not limited to, non-payment by CMSN - SFCCN or CMS/DOH, insolvency of ICS or termination of your Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Enrollee or CMS/DOH or persons, other than the ICS, acting on the Enrollee's behalf, for contracted services pursuant to your Provider Services Agreement.

Co-Payment Collections
CMS Enrollees utilizing in-network services will have no co-payments.

CLAIMS SUBMISSION
Providers shall submit all claims promptly and in accordance with the Florida Medicaid program. Claims submitted after a twelve (12) month period from the date of service will be denied. Claims should be submitted to MED3000 on a CMS-1500/UB 04 form. Claims for Child Health Check Up (EPSDT) services must be submitted on a on a CMS-1500 form. Please ensure the claim form contains the following information:

- Enrollee's name, DOB, SS#
- Date of Service
- Authorization number (if applicable)
- Diagnosis codes (ICD-9)
- Services rendered (CPT-4, DRG, Revenue code, etc.)
- Provider's full name
- Provider's Federal Tax I.D. number
- Provider's Billing name
- Provider's Billing address
- Provider's Telephone Number

Third Party Liability (TPL) Cases
It is the Provider's responsibility to alert the ICS if an enrollee has insurance coverage in addition to CMS enrollment. The ICS will then forward this information to the Florida Healthy Kid Care program for research.

Billing Address

Providers are responsible for submitting clean, complete and accurate claims to MED3000, in hard copy form or any other approved format to the following address or electronic location:

Submit Paper Claims to:

TITLE XXI
MED 3000 CMS Title XXI
P. O. Box 981733
El Paso, TX 79998-1733

EARLY STEPS
MED 3000 CMS Early Steps
P. O. Box 981626
El Paso, TX 79998-1626

SAFETY NET
MED 3000 CMS Safety Net
P. O. Box 981728
El Paso, TX 79998-1728

Submit Electronic Claims to:

MED3000 CMS TITLE XXI
Availity M3FL0014 / Emdeon EM205

MED3000 CMS EARLY STEPS
Availity M3FL0010 / Emdeon EM350

MED3000 CMS SAFETY NET
Availity M3FL001 / Emdeon EM284

http://www.availity.com/
http://www.emdeon.com/
Providers must register with a clearinghouse above and use the Payer ID listed.

INQUIRIES REGARDING CLAIMS PAYMENT

Should you have inquiries regarding claim payment or additional claim inquiries, please contact the Claims Department at **1-800-664-0146** or email **Fl-CustomerService@Med3000.com**

PROVIDER APPEALS

If a denial of payment letter is received from MED3000, please direct appeals with appropriate supporting documentation to the appropriate address above.

PCP CLINICAL SKILLS

The following Primary Care Skill set is a list of standards that have been reviewed and approved by your generalist peers, including pediatricians, internists, family physicians, surgeons and emergency room physicians.

Although this list of clinical skills or services is comprehensive, not every generalist will be able to comply with this list in its entirety. As an example, there are clinical skill sets that are not applicable to the pediatrician. Conversely, there may be eye conditions that the generalist may not feel comfortable caring for. However, it is the intention of this section to serve as a guideline, in broad terms, the services that the generalists are expected to deliver within his or her capabilities.

I. ALLERGY

A. Elicit a thorough allergy history and make use of environmental controls before referring to an allergist.

B. Treat all seasonal allergies when duration of symptoms lasts less than six (6) weeks per year or when symptoms occur in two (2) seasons, but the duration of symptoms lasts less than four (4) weeks each time. Consider referral if unresponsive to treatment.

C. Treat chronic rhinitis aggressively with at least three (3) sequential medication programs. Consider consultation or referral if the problem is unresponsive to treatment.

D. Treat hives aggressively while seeking the cause. Consider consultation or referral if the urticaria persists over two (2) week's duration.

E. May administer maintenance immunotherapy injections as prescribed by an allergist consultant once allergy testing and the institution of immunotherapy injections have been completed.

F. Diagnose and treat acute and chronic asthma. Consider consultation or referral if the treatment is unsuccessful or if hospitalization is needed. If chronic steroidal therapy is needed, consultation or referral may also be considered.

II. CARDIOVASCULAR SYSTEM

A. Diagnose and initiate treatment for significant heart disease and determine, in a timely manner, if consultation or referral is appropriate.

B. Evaluate chest pain, murmurs, and palpitations.

C. Diagnose and treat hypertension, mild congestive heart failure, and stable angina.

D. Evaluate and treat coronary risk factors including diabetes, hyperlipidemia, hypertension, and smoking.

E. Diagnose and evaluate syncope. Consult if the enrollee has a known history of heart disease or the cause has not been identified and the enrollee has a recurrent episode.

III. DERMATOLOGY

A. Treat acne with appropriate topical astringents and antibiotics for at least three (3) months using at least three (3) modalities. Consider consultation or referral if the problem is not resolved with continuing therapy or improvement ceases.

B. Consider consultation or referral for severe cystic acne.

C. Treat recurrent acne with a regimen that has been successful in the past, whether originated by the Primary Care Physician or the dermatologist.

D. Diagnose common rashes and dermatoses and treat within appropriate therapeutic protocols. Refer if there has been an unsatisfactory response to treatment or for ophthalmic involvement with herpes.

E. Diagnose and treat common hair and nail problems and dermal injuries, if appropriately trained. Refer for extensive alopecia areata or hair loss associated with infection or systemic disease.
   1. Examples of common hair problems include fungal infections, alopecia as a result of scarring or endocrine affects and ingrown hairs.
   2. Examples of common nail problems include trauma, disturbances associated with dermatoses or systemic illnesses, fungal or bacterial infections and ingrown toenail.
   3. Examples of dermal injuries include ambulatory management of minor burns, suturing lacerations, and treatment of bites and stings.

F. Diagnose and treat actinic keratoses, if appropriately trained.
   1. Perform cryotherapy, if appropriately trained.

G. Identify and consider consultation or referral for suspicious pigmented lesions, large or complicated lesions, lesions in immunocompromised members, and lesions in high-risk areas. This may include:
   1. Malignant melanoma **(always refer)**
   2. Dysplastic nevi **(biopsy or refer)**
   3. Basal cell or squamous cell carcinomas **(excise or refer)**
   4. Other suspicious lesions. Characteristics may include:
      a. Enlargement
      b. Irregular margins
      c. Color changes
      d. Bleeding
      e. Ulceration
      f. Itching or pain
   5. Lesions in high risk areas include:
      a. Head and neck
      b. Face and ears
      c. Genital area
      d. Burn scars

H. Educate the enrollee regarding the removal of certain lesions for non-diagnostic purposes. These may be considered cosmetic and, therefore, may not be covered. Examples of lesions that may be considered cosmetic include: Liver spots, spider veins, wrinkles, skin tags, uncomplicated cyst, flat asymptomatic warts, stable lipomas, seborrheic-keratosis, non-inflamed papillomas, hereditary hypertrichosis, tattoos, and non-changing pigmented lesions without special risk (vitiligo) and keloids.

IV. ENDOCRINE SYSTEM

A. Diabetes (Refer all newly diagnosed diabetics)
   1. Diagnose and manage stable insulin dependent and non-insulin dependent diabetes.
      a. Consider consultation or referral if unstable
      b. Consider consultation or referral if pregnant

c. Consider referral to education programs at contracted locations for newly diagnosed enrollees, new users of insulin, diabetics who are pregnant, those who travel, children and their parents

2. Managed uncomplicated hyperglycemia that does not require intensive insulin or pump therapy. If hospitalization is needed, consider consultation.
3. Obtain consultations for:
   a. Coma not readily reversible by glucose
   b. Poor control manifested by recurrent hypoglycemia, marked hyperglycemia, or persistent elevation of glycohemoglobin
   c. Consideration of intensive insulin or pump therapy
   d. Annual ophthalmology evaluation and especially those less than optimally controlled
   e. Development and progression of complications, including peripheral neuropathy, skin lesions, impaired renal function, and ischemic symptoms and/or findings
   f. Routine podiatry care, if PCP unable to perform
   g. Ketoacidosis

B. Thyroid Disorders
1. Diagnose and treat hypothyroidism and hyperthyroidism
   a. Consider consultation for hyperthyroidism in pregnancy, involving the endocrinologist and obstetrician
   b. Refer for radioiodine or surgical therapy if appropriate
   c. Refer for symptomatic or moderately severe exophthalmos
   d. Refer if not responding to treatment or if refractory to initial treatment
2. Diagnose multi-nodular goiter. If enrollee requires thyroid suppression, consider referral to specialist.
3. Consult for solitary thyroid nodules for consideration of biopsy and/or surgery. However, the initial work-up, i.e. thyroid scan, basic labs, etc., should be obtained by the Primary Care Physician prior to the referral.

C. Lipid Disorders
1. Diagnose and treat lipid disorders with diet and/or at least two (2) medications for a minimum of six (6) months. Refer if the enrollee has not responded within a six month to one-year time frame. Consider referring earlier if the hyperlipidemia is quantitatively severe or if atherosclerosis is known.

V. GASTROINTESTINAL SYSTEM

A. Diagnose and treat common GI conditions including esophageal and reflux disease, hiatal hernia, hyper acidic and duodenal ulcer disease, infectious diarrhea, protracted vomiting, functional bowel disease, obstruction, diverticulitis and peptic ulcer disease.
1. Refer to surgeon for suspected bowel obstruction
2. Refer any of the above conditions if:
   a. The diagnosis is unclear
   b. The symptoms do not respond to therapy
   c. The condition is refractory to initial therapy

d. Refer if abnormalities are found, there is associated bleeding, weight loss, or malabsorption problems
e. Enrollee needs colonoscopy or gastroscopy

B. Initiate evaluation and diagnosis of liver disorders. Consultation or referral should be considered for undiagnosed hepatocellular disease or obstruction, for new or intractable ascites, or in the presence of fever.

C. Diagnose and treat enrollees with acute pancreatitis and those with chronic relapsing pancreatitis responding to conservative treatment. Obtain consultation or referral for those enrollees with:
1. Initial episode of acute pancreatitis
2. Consider early surgical consultation if course of treatment is unfavorable or complicated.
3. Enrollees with malabsorption secondary to chronic pancreatitis.

D. Diagnose and treat symptomatic hemorrhoids. Refer if surgical intervention is required.

VI. GENERAL SURGERY

A. Diagnose symptomatic gallbladder disease

B. Perform clinical breast exams
1. Aspirate breast cyst (if trained) and send to pathology.

C. Perform incision and drainage of simple soft tissue infections, if trained

VII. FEMALE REPRODUCTIVE SYSTEM

A. Provide pelvic exams and PAP smears for female enrollees, if trained

B. Diagnose and treat common GYN conditions including vulvovaginitis, sexually transmitted diseases, and may manage menstrual disorders such as dysmenorrhea or vaginal bleeding if appropriately trained. Consider consultation or referrals for the following:
1. Vaginal warts
2. GYN complaints unresponsive to medical management
3. Complex or unusual cases
4. Suspected or confirmed ectopic pregnancy
5. Pelvic pain associated with abnormal vaginal bleeding
6. Uncertain clinical diagnosis which would benefit from another opinion or laparoscopy
7. Women for whom pregnancy would represent high risk for the mother or fetus **(should have pre-pregnancy counseling**)
8. Moderate to severe endometriosis

C. Diagnose pregnancy and refer for Obstetrical care

D. Diagnose abnormal early pregnancy and refer for:
1. Vaginal bleeding
2. Threatened abortion
3. Incomplete abortion
4. Missed abortion
5. Molar pregnancy

E. Provide contraceptive counseling and management

F. Diagnose pre-menstrual syndrome based on history and symptoms calendar, and manage with hormones, NSAIDS, diuretics and other symptomatic treatment as appropriate. Refer refractory cases.

G. Order screening mammogram according to an approved schedule Identify breast lumps and refer for surgical management

VIII. HEMATOLOGY

A. Diagnose and institute appropriate testing and treatment for iron deficiency anemia, macrocytic anemia, hemolytic anemia, and sickle cell anemia. Refer for:
   1. Hypochromicrocytic anemia not due to iron deficiency
   2. Anemia not responding to treatment
   3. Inability to identify the cause
   4. Complications of sickle cell anemia
   5. Spherocytosis, immune-hemolytic anemia, thrombotic thrombocytopenic purpura, acute hemolytic crisis, and hemolysis of unknown cause.
   6. Bone marrow exam

B. Recognize the anemia of chronic disease

C. Refer for:
   1. Suspected porphyria and hemochromatosis
   2. Unexplained polycythemia
   3. Pancytopenia
   4. Leukemia, myelodysplastic disorders, myeloproliferative disorders and lymphomas.
   5. Severe neutropenia
   6. Abnormal white blood cell morphologies
   7. Undiagnosed splenomegaly, adenopathy, or hypergammaglobulinemia.

D. Primary Care Physician may participate with the oncologist in the management of chronic lymphocytic leukemia.

E. Recognize bleeding disorders and diagnose most platelet and coagulation disorders. Treat stable active abnormalities. Refer for:
   1. Undiagnosed conditions
   2. Initial management
   3. Bone marrow exam

F. Identify the need for and administer transfusion of blood products.

IX. NERVOUS SYSTEM

A. Perform a neurological history and examination that includes a mental status examination evaluation of the cranial nerves, motor and sensory function, coordination, gait, and reflexes.

B. Diagnose and treat neurologic pain syndromes, including headaches and migraines, myofascial pain and TMJ syndrome, low back pain, lumbosacral disc disease and sciatica. Consider consultation or referral if:
   1. There is a neurologic deficit present
   2. Condition unresponsive to conservative measures
   3. No improvement after six (6) weeks of therapy
   4. Suspected intracranial disorder

C. Manage uncomplicated stroke and/or TIA

D. Evaluate syncopy and seizures. Refer for:
   1. Initial consultation to confirm diagnosis and establish a treatment plan
   2. Confirmed seizures
   3. Recurrent seizures
   4. Condition of drug toxicity

5. Considering discontinuing anti-convulsants

E. Consider consultation for:
   1. Dementia
   2. Intention tremor
   3. Tic douloureux
   4. Intractable neurological symptoms
   5. Any condition in which the cause is unclear
   6. Any condition in which there is an unsatisfactory response to treatment.

X. MUSCULOSKELETAL SYSTEM

A. Diagnose and treat low back pain and sciatica without neurological deficit. Consider consultation or referral if condition unresponsive to conservative measures and/or if no improvement after six (6) weeks of therapy.

B. Diagnose and treat common musculoskeletal medical and mild traumatic problems, sprains, and acute inflammatory conditions. Consider consultation and referral for:
   1. Intractable problems
   2. Fractures
   3. Lock knee
   4. Unstable or apparent ligament tears, especially if the standing x-ray shows joint narrowing or gross destruction of articular surfaces.
   5. Severe sprains.

C. Diagnose and refer non-displaced fractures of the clavicle, scapula, humerus, radius, ulna, hand, fingers, pelvis, patella, fibula, metatarsal, and toes. These fractures will generally be treated by splints and slings.

D. Manage chronic pain if consultation has ruled out surgery.
   1. Soft tissue injections by the Primary Care Physician (if trained) are encouraged when clinically appropriate.

E. Diagnose and treat common foot problems conservatively. Conservative care includes education about hygiene, proper cutting of toenails, and the treatment of corns and calluses including paring, chemical treatment (if trained) and education for home debridement by the enrollee. The enrollee should also be instructed in proper footwear, especially if the enrollee is diabetic or has peripheral vascular disease. Consider consultation or referral if:
   1. Suspect osteomyelitis, gangrene, or deep abscess
   2. Persistent intractable difficulty
   3. Post surgical problems
   4. Prosthesis or orthotic needs

XI. OPHTHALMOLOGY SERVICES

A. Perform thorough ophthalmology history including family history, symptoms and subjective visual acuity.

B. Perform a basic eye examination including distant, near and color vision testing, gross visual field testing by confrontation, alternate cover testing, physical examination including a direct fundoscopy without dilation, extra-ocular muscle function evaluation and red reflex testing in pediatric members.

C. Diagnose and treat uncomplicated ocular trauma including:
   1. Corneal or conjunctival abrasions

2. Contusions of the eye

Treatment should include fluorescein staining and patching.

D. Consider consultation or referral for:
   1. All corneal burns after initial irrigation.
   2. Embedded, metallic, central or unremovable foreign bodies.
   3. Lacerations of the cornea or sclera or deep lid lacerations
   4. Hyphema
   5. Irregular pupil
   6. Proptosis
   7. Edema
   8. Suspected retinal detachment or intraocular foreign body
   9. Sudden vision loss or change
   10. Persistent severe pain without cause
   11. Absent red reflex
   12. Pediatric enrollees with disconjugate gaze or other ophthalmologic problems.
   13. Periodic examinations on diabetics over the age of 30 or those who are poorly controlled.
   14. Periodic examinations on enrollees who are taking Plaquenil.
   15. Iritis

E. Diagnose and treat common eye conditions including viral, bacterial and allergic conjunctivitis, blepharitis, hordeolum, chalazion, small subconjunctivial hemorrhage and dacryocystitis. Consultation or referral recommended when:
   1. There is a high index of suspicion for Herpes
   2. Suspicion for Iritis
   3. Condition unresponsive to treatment within two (2) or three (3) days

XII. OTOLARYNGOLOGY SERVICES

A. Diagnose and treat tonsillitis and streptococcal infections. Consider consultation or referral if:
   1. Acute tonsillitis unresponsive to four (4) weeks of antibiotic therapy.
   2. Recurrent infections within three (3) documented episodes within four (4) months or six (6) within one year.
   3. Tonsillar hemorrhage
   4. Suspected tonsillar malignancy
   5. Prolonged or recurrent peritonsillitis/peritonsillar abscess

B. Evaluate and treat acute otitis media. Consider consultation or referral if:
   1. Infections are unresponsive to two (2) different antibiotic courses of care.
   2. Dizziness, facial weakness, mastoiditis, chronic draining ear or hearing loss.
   3. Tympanocentesis
   4. Acute otitis media in a child with compromised host resistance.
   5. Persistent painful bullae of TM unresponsive to analgesic measures.

C. Diagnose and treat otitis externa. Consider consultation or referral if:
   1. Patient fails to improve within 4 to 5 days.
   2. Enrollee is a diabetic, immunocompromised, has herpes zoster persistent otalgia (refer immediately).

D. Treat acute and chronic sinusitis with up to two (2) courses of antibiotics. Refer if:

1. Infection is totally unresponsive with 72 hours. Consider earlier referral if infection is in frontal sinusitis or with periorbital cellulitis.
2. Symptoms that persist for 20 days or more
3. Persistent headache
4. Recurrent infections

E. Treat nasal obstruction and vasomotor allergic rhinitis. Consider consultation or referral if problem persists more than three (3) months.

F. Remove ear wax

G. Consider consultation or referral for Bell's Palsy, if diagnosis is unclear

H. Consider consultation or referral for acute hearing loss, for persistent hearing loss not attributable to fluid or wax, for parotid masses, for hoarseness persistent for more than three (3) weeks and for hemoptysis.

I. Diagnose and treat acute parotitis and acute salivary gland infections with antibiotics. Refer if:
1. Suspicious for abscess, calculus or neoplasm
2. Failure to respond to antibiotics within one week
3. Recurrent infections

J. Perform indirect layrngoscopy, if appropriately trained and office is adequately equipped.

XIII. PULMONARY SYSTEM

A. Evaluate symptoms and findings including chest pain, cough, dyspnea, hyper somnolence, increased or decreased breath sounds, rales, wheezes, cyanosis or clubbing. Obtain pulmonary function test with or without bronchodilators as indicated.

B. Diagnose and treat common respiratory conditions including asthma, acute bronchitis, pneumonia, and COPD.

C. Consider consultation or referral for the following:
1. Persistent pleural effusions not due to heart failure
2. Unresolved pneumonia or recurrent pneumonia
3. Hemoptysis- persistent or of suspicious etiology
4. Lung mass
5. Interstitial disease
6. Sarcoidosis
7. Tuberculosis
8. Unusual infections
9. Respiratory failure
10. Poor response to treatment
11. Percutaneous lung biopsies, pleural biopsies or supraclavicular node biopsies
12. Acute lung injury
13. Suspected sleep apnea

D. Recognize opportunistic infections as possible manifestations of immunodeficiency

XIV. PSYCHIATRY

The Primary Care Physician should recognize mental illness and symptoms when seeing enrollees in order to avoid excessive resource consumption for somatic symptoms when a psychiatric diagnosis is the underlying cause. Some of the functions of the Primary Care Physician may include:

A. Perform developmental and psychosocial histories and mental status examinations when indicated by psychiatric or somatic presentations. Important somatic presentations include: fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems.

B. Diagnose physical disorders with behavioral manifestation

C. Make presumptive diagnoses of psychosis, major depressive disorders, other mood disorders including manic or hypo-manic episodes, dementia, substance abuse, eating disorders, anxiety disorders, attention deficit disorder and some other childhood disorders, adjustment disorders and personality disorders.

D. Institute psychopharmacological intervention, when appropriate, and adjunctive supportive psychotherapy for the conditions listed above.

E. Refer for the following:
   1. Persistent substance abuse
   2. Non-compliance with or abuse of psychopharmacological, prescribed or over the counter medication.
   3. Psychotic disorder
   4. Suicidal ideation, plan or intent, or depression with vegetative symptoms.
   5. Severe disassociative disorders, severe eating or pain disorders, and post–traumatic stress disorders.
   6. Suspected Attention Deficit Disorder (ADD) or Hyperactive Attention Deficit Disorder (HADD) if there is an unsatisfactory response to initial medication.
   7. Enrollee request for consultation or persistent dysfunction without resolution of the presenting symptom

F. Provide maintenance medication management after stabilization by a psychiatrist or if long term psychotherapy continues with a non-physician therapist.

XV. RHEUMATOLOGY

A. Diagnose and treat common rheumatologic conditions including non-specific musculoskeletal pain, bursitis, tendinitis, and osteoarthritis. Consider consultation or referral if:
   1. Unresponsive after two (2) to three (3) months of therapy
   2. Functional impairment exists
   3. Intractable pain
   4. Serious collagen vascular disease is found

B. Diagnose and treat acute inflammatory arthritic diseases. This includes aspiration and/or injections when medically appropriate and necessary, if trained and experienced. Consider consultation or referral if:
   1. If unresponsive to treatment plan
   2. To establish a long-term management plan of care
   3. If not experienced in small joint injections
   4. If surgical treatment is being considered

C. Diagnose and treat uncomplicated collagen diseases, cutaneous and systemic vasculitides. Consider consultation or referral depending on the extent and severity of manifestations or complications. These may include:
   1. Condition refractory to initial treatments
   2. Diagnostic uncertainty

3. Immunosuppressive treatment is needed to allow tapering of corticosteroids.
4. Temporal arteritis **(refer immediately)**

XVI. UROLOGY

A. Diagnose and treat both initial and recurrent urinary tract infections. Consider consultation or referral if:
   1. Identified anatomical abnormalities
   2. Persistent or recurrent infections despite chemprophylaxis
   3. In enrollees with marked urinary frequency or irritability with negative urinalyses and cultures.

B. Diagnose and treat sexually transmitted diseases including appropriate tests for chlamydia and gonorrhea. Consider consultation or referral for:
   1. Urethral stricture
   2. Condition unresponsive to treatment
   3. Complications

C. Evaluate hematuria, prostatism and prostatic enlargement, and scrotal or peritesticular masses. Consider consultation or referral if:
   1. Hematuria is due to a mass or has abnormal cytology
   2. Hematuria is unexplained and persistent or recurrent
   3. Anatomic or neurologic abnormalities are identified
   4. Condition unresponsive to treatment
   5. Any condition suspicious for malignancy
   6. Enrollee has a testicular mass
   7. Enrollee has a hydrocele, spermatocele or varicocele that are large enough to cause intolerable symptoms
   8. Cause unknown

D. Diagnose and treat prostatitis and epididymitis. Refer **immediately** if:
   1. Acute onset in young males that suggests testicular torsion
   2. Condition occurs post-vasectomy
   3. Recurrent infections
   4. No response to treatment

E. Diagnose and manage small renal calculi on an outpatient basis. Consider consultation or referral if:
   1. The stone is greater than 4 mm
   2. The stone is in the proximal portion of the ureter
   3. Consideration of lithotripsy, stenting or surgical removal
   4. Fever
   5. Unresponsive to symptomatic treatment
   6. Obstruction has occurred

F. Evaluate abnormal kidney function tests, incontinence, impotence and male factor infertility prior to a referral to a specialist. The evaluation for the specific condition may include, but not be limited to the physical exam, IVP, semen analyses, endocrine studies, etc.

XVII. **VASCULAR SURGERY**

A. Diagnose abdominal aortic aneurysms (A.A.A.) by examination and ultrasound. Consider consultation or referral if:
   1. Enrollee is symptomatic
   2. A.A.A. enlarging
   3. A.A.A. 5 cm or greater in diameter

B. Diagnose thoracic aneurysms by exam and appropriate diagnostic tests. Consider consultation or referral if:
   1. Aneurysm is 5 cm in diameter or greater
   2. Aortic insufficiency or dissection
   3. Enrollee symptomatic

C. Diagnose and treat venous disease. Refer for:
   1. Uncertain diagnosis
   2. Complications such as refractory stasis ulcers or embolization

D. Diagnose and refer for arterial problems such as gangrene, ischemic ulcers or ischemic pain at rest.

ENROLLEE INFORMATION

PRIMARY CARE PROVIDER ASSIGNMENT

Every enrollee within the CMSN - SFCCN must have an assigned Primary Care Provider (PCP) who will coordinate his/her medical care within the CMSN - SFCCN. This provider/physician will handle the enrollee's primary care medical needs and will arrange for specialty and hospital care when necessary.

When enrolling within the CMSN - SFCCN, each enrollee will either choose a Primary Care Provider or be assigned one when he/she does not make an active choice. If a new enrollee has chosen or is assigned to a clinic setting or a group practice by name, the provider office needs to internally assign the member a PCP. The assigned PCP should be the PCP of record whenever possible in order to facilitate continuity of care.

Primary care providers not willing to serve an enrollee or family should send a letter to the Enrollee Services Department detailing the circumstances and reason for this action. Enrollee Services in turn will transfer the enrollee to another PCP. If the Primary Care Provider had been assigned the enrollee in question and had rendered care prior to the submission of this letter, the Primary Care Provider is responsible to provide any necessary urgent or emergent care until such time that the enrollee has become established with another Primary Care Provider.

PCP TRANSFER REQUESTS

The CMSN - SFCCN strives to maintain a positive relationship between the enrollee and his/her primary care provider. Enrollees may request a PCP change (transfer) by calling the CMSN - SFCCN Enrollee Services Department at 1-866-202-1132. Transfer requests may be initiated by the enrollee or the enrollee's legal guardian. If the request is received on or before the 15th of the month, the effective date of the change will be the first (1st) of the next month. If the request is received after the 15th of the month, the effective date will be the 1st of following month after next. The enrollee will receive a new ID card from Enrollee

Services indicating the new PCP name. The PCP is expected to continue providing care until the effective date of the change.

Transfers resulting due to PCP Terminations

The following process occurs when a PCP terminates his/her contract with the CMSN - SFCCN:

- Upon receipt of the PCP's termination notice, the CMSN - SFCCN contacts the enrollee's CMS Nurse Care Coordinator.
- The CMS Nurse Care Coordinator notifies the enrollee of the PCP's termination and explains that a new PCP must be selected. If needed, the CMS Nurse Care Coordinator will supply the enrollee with information regarding the available PCPs.
- After the enrollee has selected their new PCP, the CMS Nurse Care Coordinator notifies the CMSN - SFCCN.

ENROLLEE RIGHTS AND RESPONSIBILITIES

The CMSN - SFCCN strives to foster enrollee satisfaction, respect, and availability of information through open communications. We, therefore, have written the following Enrollee Rights and Responsibilities.

- Each enrollee has the right to be treated with respect, courtesy, and dignity.
- Each enrollee has the right to have his/her privacy protected.
- Each enrollee who requests advice or assistance has the right to be assisted in a prompt, courteous and responsible manner.
- Each enrollee has the right to be provided with information about his or her diagnosis, treatment, and prognosis in terms that are understandable to him or her.
- Each enrollee has the right to have his or her medical record and all other information kept confidential unless permission to release such information has been given by the enrollee or the release is required by law.
- Each enrollee has the right to participate in decisions regarding his or her care.
- Each enrollee has the right to express grievances regarding the program or any violation of his/her rights.
- Each enrollee has the responsibility to try to be considerate and respectful of all treatment staff and to cooperate with the treatment staff. This includes following instructions from those rendering health care services and enrollees providing the staff with the information they need. If the enrollee has questions or disagrees with the treatment plan, he or she has the opportunity to discuss it with his or her doctor and the other treatment staff.
- Each enrollee has the responsibility to carry his/her ID cards at all times and call his/her doctor or other health care providers when an appointment cannot be kept.
- Each enrollee has the responsibility to call his/her doctor and the Enrollee Services Department if he/she has a change of address or telephone number.
- Each enrollee has the right to be made aware of experimental treatment programs involving their care and the right to refuse to participate.

- Each enrollee has the responsibility for following the plan of treatment outlined by his or her physician or, if not possible, to request a new plan of treatment or alternately request assignment to another doctor.
- Each enrollee has the right to change PCP, specialist, dentist, ancillary providers or vendors upon request effective the first (1st) of the following month, dependent upon when the request is received.

COMPLAINTS, GRIEVANCES & APPEALS

COMPLAINT PROCEDURE

A complaint is an oral or written expression of dissatisfaction by an enrollee that is resolved by close of business the following business day. Examples of complaints include, but are not limited to, rudeness of provider, quality of services provided or quality of care rendered. An enrollee can register a complaint with their CMS Nurse Care Coordinator or CMSN-SFCCN Enrollee Services.

GRIEVANCE PROCEDURES

A complaint that is not resolved by close of business the following business day then becomes a grievance. A grievance can be filed orally or in writing. If this occurs, the Grievance Coordinator may contact you to obtain information about the grievance.

A sample Grievance form follows.

Upon request, the CMSN - SFCCN will provide an enrollee/provider with the below grievance form within 3 business days of the request. Enrollees/Providers have a minimum of one year from the date of the occurrence to file a grievance with the CMSN - SFCCN.

CMSN - SFCCNGRIEVANCE FORM

ENROLLE NAME:	DATE:
ADDRESS:	PHONE:
PROVIDER:	I.D.:
ADDRESS:	PHONE:
CMSN - SFCCN	PHONE: 1 (866) 202-1132
ADDRESS: 1643 Harrison Parkway Building H, Suite 200 Sunrise, FL 33323	
DESCRIPTION OF GRIEVANCE	
DATE REVIEWED BY CMSN - SFCCN GRIEVANCE COMMITTEE:	
GRIEVANCE RESOLVED TO SATISFACTION OF ENROLLEE: YES NO	

APPEALS PROCEDURE

An appeal is a formal request from an enrollee to seek a review of an action taken by the CMSN-SFCCN. An action is a denial, reduction, suspension or termination of a service. An appeal may be oral or written. An oral appeal must be followed by a written filing. Acknowledgement of an appeal request will be sent by the CMSN-SFCCN within 10 days of receipt of the appeal. An appeal must be filed within 30 days of receipt of the notice of action. The CMSN-SFCCN has 45 days to resolve an appeal. Once a resolution is determined, CMSN-SFCCN will provide notification of its decision within two business days.

An expedited appeal can be requested if warranted by the enrollee's diagnosis or condition. CMSN-SFCCN will respond to an expedited appeal request within 72 hours.

An enrollee can also request a state level hearing by the Statewide CMS Grievance and Appeal Panel in addition to and at the same time that the CMSN-SFCCN is working on the appeal. This can be done by writing to them at:

The Statewide CMS Grievance and Appeal Panel
4052 Bald Cypress Way, Bin #A06
Tallahassee, FL 32399-1707.

Services Requiring Authorization for CMS Title XXI and Title XIX MMA Specialty Plan

Call or fax the CMSN UM Department assigned to the member or enter your request via the Provider Portal https://cms.einfosource.med3000.com SFCCN Phone 1-866-202-1132 or Fax (844) 806-0397
Prior Authorization – *supporting clinical documentation is required* *Prior authorization requests require the submission of supporting clinical documentation for medical review. Failure to provide clinical information can result in a delay or denial of the request.*
Applied Behavioral Analysis (therapy) *Services will be authorized by eQHealth for TXIX MMA. ICS's will authorize services for TXXI*
By Report items per the Medicaid Fee Schedule
Durable Medical Equipment (all items including Insulin Pumps, Custom Wheelchairs, and Scooters) *For services that have a PA indicator per the Medicaid Fee Schedule*
Elective Surgical Procedures (including cosmetic and Plastic/Reconstructive procedures per Medicaid Physician Fee Schedule) *Reference attached list*
Experimental / Investigational Treatment (See Definition Below) *Those newly developed procedures undergoing systematic investigation to establish their role in treatment or procedures that are not yet scientifically established to provide beneficial results for the condition for which they are being used.*
Hearing Services / Hearing Aids / Augmentative or Alternative Communicative Systems *For services that have a PA indicator per the Medicaid Fee Schedule*
Home Health Care services (including Home Health Aids, Nursing Visits, and Infusion Services)
Inpatient Admissions (including Mental Health and Skilled Nursing Facilities) In and Out of Network
Mental Health Day Treatment Programs
MRIs, CTs, PET scans
Nutritional Supplements / Enteral & Parenteral Nutrition *For services that have a PA indicator per the Medicaid Fee Schedule*
Orthotics and Prosthetics *For services that have a PA indicator per the Medicaid Fee Schedule*
Orthodontia *For services that have a PA indicator per the Medicaid Fee Schedule*
Out of network / Out of State Services
PPEC (Signed Plan of Care Needed) *Services will be authorized by eQHealth for TXIX MMA. ICS's will authorize services for TXXI*
Private Duty Nursing
Request that Exceeds Medicaid Limits
Therapy Services (PT, OT, Speech and Respiratory) (Signed Plan of Care Needed) *This requirement includes Therapy Services for Dually Enrolled Children in Early Steps*
Transplants and Related Care *Professional services rendered in the office for participating providers would not require prior authorization*
Vision Services (Contact Lenses Specialty (non-standard) Glasses) *For services that have a PA indicator per the Medicaid Fee Schedule*
Notification Required – service does not require prior authorization just notification that that service was rendered for coordination of care purposes only
Emergency Room Visit - Notification Only **Observation Stays – Notification Only**

PRIOR AUTHORIZATION

InterQual and other nationally recognized criteria will be used to evaluate requests for medical appropriateness/necessity.

Requests for services that do not meet criteria due to lack of information will be pended and returned to the requesting physician/provider's office for additional information. If, after receiving the additional information, the request does not meet InterQual and/or other nationally recognized criteria, the request will be forwarded to the SFCCN-CMS Medical Director for review and determination.

Authorization will be required for all items listed on the previous authorization list.

Payment for any services on the prior-authorization list which are rendered/performed without an authorization number will be denied for lack of authorization.

Authorizations are valid for up to 6 months.

PRIOR AUTHORIZATION FOR NEW CMSN - SFCCN ENROLLEES

Written documentation of prior authorization of ongoing services will be honored within the designated time frame of enrollment in the CMSN - SFCCN or until the CMSN - SFCCN's PCP reviews the enrollee's treatment plan, whichever comes first. Services need to have been pre-arranged prior to enrollment in the ICS. These services include:

a) Prior existing orders (including Home Health & Durable Medical Equipment)
b) Prior appointments and surgeries
c) Prescriptions (including prescriptions at non-participating pharmacies)

For patients hospitalized at the time of enrollment into the CMSN - SFCCN, the ICS will become responsible for days on or after the initial date of enrollment. The timeframes are defined as: For assigned enrollment – Sixty (60) days after the effective date of enrollment in the ICS or until the PCP reviews the enrollee's treatment plan, whichever comes first.

USE OF OUT-OF NETWORK PROVIDERS

In situations wherein (1) the requested service is not available within the established CMSN - SFCCN Network or (2) the Primary Care Provider cannot get an appointment with an in-network specialist for an enrollee within thirty (30) days, PCPs may request prior-authorization for the use of an out-of-network provider.

All out-of-network services require prior-authorization from the CMSN - SFCCN, including referrals to specialists (recommended by the Primary Care Provider). Providers must fax the Medical Management Department a completed prior-authorization form and valid written documentation justifying the need for utilizing an out-of-network provider. The justification should include information regarding the services being unavailable in the existing CMSN - SFCCN network.

Please refer to the list of services that require prior authorization.

SERVICE INFORMATION

EMERGENCY SERVICES UTILIZATION PROCEDURES

Notification of Emergency Room Treatment

All notifications of Emergency Room services must be made to 1-866-202-1132.

The enrollee in the emergency room who becomes admitted will require a separate authorization number to be issued by the ICS at the time of notification and determination of medical necessity.

Scope of Service

Emergency services will be provided to all enrollees in accordance with State and Federal laws. The CMSN - SFCCN will monitor emergency room utilization. Emergency services and care are defined as: medical screening, examination and evaluation by a physician or to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition is determined to exist, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital does not require prior authorization. Once the Utilization Management Department is notified of the Emergency Room visit, the PCP will be notified as well via fax or telephone in order to initiate appropriate follow up care.

Enrollees shall not be sent to the Emergency Room for the following conditions:

- Routine follow-up care
- Follow-up for suture or staple removal
- Non-emergent care during normal business hours

OUTPATIENT HOSPITAL SERVICES

Referrals for outpatient hospital services will be processed by the Utilization Management department. Please refer to the section of this manual under Utilization Management entitled Referral/Authorization Process.

Outpatient hospital services are defined as those preventative, diagnostic, therapeutic or palliative services provided at a licensed hospital or an outpatient basis under the direction of a physician or dentist. These outpatient hospital services include emergency room, dressings, splints, oxygen and physician ordered supplies necessary for the clinical treatment of a specific diagnosis or treatment.

There are no outpatient limitations for CMS enrollees under the age of 19.

The reimbursement referred to above for outpatient hospital services excludes surgery, obstetrical procedures, dialysis services, the fitting of burn garments and the garments themselves.

CMSN - SFCCN providers may not bill outpatient charges for office visits and related procedures. Primary care services provided in hospital-owned outpatient clinics and satellite facilities cannot be billed on the UB 04 claim form. Physician services must be billed using the CMS 1500 claim form.

HOME HEALTH SERVICES

Home Health Services, whether at the time of discharge from a hospital or PCP from the community, must be ordered by the ordering physician or the PCP. The request for authorization should be faxed to the Medical Management Department either by the vendor, provider or CMS Nurse Care Coordinator. The CMS Nurse Care Coordinator refers the enrollee to a network vendor or provider.

A plan of care should be submitted with the Authorization/Referral Form. The Plan of Care/Orders from the attending physician shall include the following per the contract:

- Enrollee's acute or chronic medical condition that causes the enrollee to need home health care.
- Medical Necessity for the service(s) to be provided at home (enrollees must be deemed homebound).
- The specific Home Health service(s) needed.
- The frequency and duration of the service(s).
- The minimum skill level of staff that can provide the service(s)

Follow-up with the enrollee during the course of treatment under Home Health will be conducted by the CMS Nurse Care Coordinator. The CMS Nurse Care Coordinator may also notify the PCP/ordering provider of the enrollee's progress with treatment. This action does not replace the PCP/HH Agency communication; it enhances collaboration between all parties.

Note that the PLAN OF CARE FOR HOME HEALTH CARE WILL EXPIRE EVERY 60 DAYS and will be updated by the Home Health Agency. FOR THOSE CHILDREN RECEIVING ONGOING HOME HEALTH CARE SERVICES, THE ORDERING PHYSICIAN MUST EVALUATE THE PATIENT AT A MINIMUM OF EVERY 6 MONTHS. Plans of Care will not be approved without documentation of physician evaluation of the enrollee at a minimum of every 180 days. If the PCP/provider does not certify a continued need, the enrollee and the Home Health Agency will be notified that the CMSN - SFCCN will not be authorizing continued services and will not be responsible for payment if the service is rendered past the date of the notification or disenrollment of the enrollee. Please note that because the CMSN - SFCCN has contracted home health care agencies, enrollees may not directly seek services or call the companies. The PCP/provider needs to coordinate the care with the home health company and the enrollee.

DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES

Durable Medical Equipment (DME) must be ordered by the provider and the referral request must be submitted to the Medical Management Department. A physician's order should be submitted along with the Authorization/Referral form. The enrollee may be contacted by the CMS Nurse Care Coordinator during the course of treatment.

The CMSN - SFCCN's Medical Management Department may also contact the provider

to discuss the enrollee's progress with requested plan of care and may recommend alternatives, if indicated. For those children receiving on-going DME requiring renewals, the attending physician must evaluate the patient at a minimum of every six (6) months. Recertification will not be approved without documentation of physician evaluation of the enrollee at a minimum of every 180 days. If the PCP/Provider does not certify a continued need, the enrollee and the DME provider will be notified that the CMSN – SFCCN will not be authorizing continued services, and will not be responsible for payment if the service is rendered past the date of the notification or disenrollment of the enrollee.

LABORATORY SERVICES

Laboratory services will be utilized at one of the Network Hospital Facilities or by any laboratory that provides services for Medicaid recipients. Quest Diagnostics is the preferred but not obligatory laboratory.

OUT OF SERVICE AREA MEDICAL NEEDS

Procedures/services that are requested out of the service area must be prior authorized and deemed medically necessary by the Utilization Management Departments. At the time of the referral to the Utilization Management Department, the supporting documentation must accompany the referral request. Emergency room requests will be authorized and reviewed retrospectively from claims data by the ICS's Medical Director.

All Out-of-Service area requests for service will be reviewed and determinations on delivery of care will be made by the CMSN - SFCCN's Medical Directors. Out-of-Service area authorizations will be determined by the availability of services offered within the network and medical necessity.

CMS AFFILIATED SPECIALTY PROGRAMS

Participating providers are encouraged to utilize CMS Affiliated Specialty Programs for referrals, when appropriate. Following are some of the CMS Affiliated Specialty Programs that apply to children of all ages. For detailed information regarding these centers, contact your local CMS office at:

Miami-Dade	1-866-831-9017
Marathon	1-800-342-1898
Ft. Lauderdale	1-800-204-2182
West Palm Beach	1-877-822-5203
Naples	1-239-552-7400
Ft. Myers	1-800-226-3290
Sarasota	1-800-235-9717
Ft. Pierce	1-800-226-1354

CHILDREN'S CARDIAC PROGRAM

A network of cardiac services has been approved by Children's Medical Services (CMS). Clinic services are available at CMS area office locations for children and young adults under the age of 19 years who meet the CMS financial and clinical eligibility criteria. Cardiac catheterization and surgical facilities have also been approved to provide families with access to tertiary centers for diagnostic or interventional catheterizations as well as surgical services. These services are coordinated with each patient's local CMS physician and are family-centered.

The CMS cardiac program strives to lessen children's illness from their cardiac condition by aiding in assessment prior to their involvement in physical activities and involving parents and children in developing an appropriate life style. In addition, the program is developing a system to provide rapid transmission of diagnostic studies for evaluation and to offer area-wide educational programs. Cardiac services can be accessed through any of the CMS area offices and approved cardiac centers throughout the state.

CMS CRANIOFACIAL/CLEFT LIP & CLEFT PALATE PROGRAM

Through Children's Medical Services a network of cleft palate clinics and craniofacial centers has been approved for infants and children with cleft lip, cleft palate, and craniofacial anomalies who are sponsored by CMS. Private patients also have access to this system of interdisciplinary family-centered care throughout the state. All infants and children with craniofacial anomalies may be referred to a CMS cleft palate clinic or craniofacial center by their parent, private practitioner or other provider(s).

When an infant is born with cleft lip, cleft palate or craniofacial anomalies, the birth hospital staff and the parents receive individualized feeding instruction for the baby and educational materials (brochures, videos, etc.) while in the hospital. In addition they are informed about the services which are provided by CMS. The parents are offered an initial hearing screening for their newborn at the nearest infant hearing impairment center. For all infants and children with cleft lip, cleft palate, or other craniofacial anomalies the program staff arranges an initial, comprehensive evaluation by a CMS approved cleft palate clinical team at no cost to the family. The most complex children may be referred for further evaluation by a CMS approved craniofacial center team when requested by the Cleft Palate Team Director or CMS Medical Director.

LIVER TRANSPLANT PROGRAM

The State of Florida Pediatric Liver Transplant Program is designed to provide an integrated infrastructure to support pediatric liver transplantation in the state of Florida. The statewide program is composed of Pediatric Transplant teams at the University of Miami/Jackson Memorial Hospital and the University of Florida/Shands Children's Hospital. Program goals include decreasing costs and improving clinical outcomes for children with liver transplants. The program emphasizes coordinated case management and education of the patient, family and primary care provider.

Currently, there are more than 300 children residing in over 50 counties in Florida receiving follow-up transplant care as part of this program. In the state of Florida, children with liver transplants receive medical care through coordinated efforts between the transplant center and the primary healthcare provider. Coordinating care with CMS physicians and primary care providers is an integral part of the program. As a result of case management and enhanced educational services, most of these children are able to receive primary health care in their local communities. Importantly, medical costs are minimized and the quality of life improved for these children and their families. The State of Florida Pediatric Liver Transplant Program, through an infrastructure providing coordinated care and education, is able to decrease subsequent hospitalizations and re-transplants while improving clinical outcomes for children with liver transplants.

PEDIATRIC HEMATOLOGY/ONCOLOGY PROGRAM

The Pediatric Hematology/Oncology Program is a regionalized program that was initiated in 1988 when testing for blood disorders, such as sickle cell disease, was added to the Newborn Screening Program. The CMS Hematology/Oncology Centers around the State provide care for infants, children, and youth diagnosed with cancer or blood disorders. When a Newborn Screening Program test for blood disorders is not normal, the Centers also provide follow-up testing to confirm a diagnosis.

REGIONAL PERINATAL INTENSIVE CARE CENTERS

The major goal of the Regional Perinatal Intensive Care Centers Program is to deliver optimal medical care to women with high-risk pregnancies and to sick/preterm newborns. Studies have indicated that maternal, fetal, and neonatal mortality rates can be reduced through early identification and early and continuous provision of specialized health care to pregnant women and newborns at high risk for disease, death, or disability.

Regional Perinatal Intensive Care Centers have been designated throughout the state in order to improve the delivery of perinatal care services through:

- the concentration of high cost specialized health care and clinical expertise in designated hospitals in the state,
- the provision of community- based consultative prenatal services, and
- the provision of specific education for health care professionals involved with perinatal care.

CMSN - SFCCN QUALITY MANGEMENT PROGRAM

The CMSN - SFCCN has as its mission to improve the quality of care to CMS recipients within a managed care system of delivery, to provide a high standard of health care and education, to improve the health status of the community, and to earn patient and customer satisfaction. We believe that this can best be accomplished with each enrollee having a Primary Care Provider as this fosters continuity of care. To accomplish this, a comprehensive Quality Improvement Program has been developed.

The medical services your practice provides will determine which of the following quality indicators will be assessed. The specific indicators include at least:

- Lack of access to services after PCP office hours.
- Mortality of enrollees
- Health status indicator or enrollee
    1. Immunization
       % of members at age 2 who have completed the basic immunization rates.
    2. Well child health care utilization (Preventive Care)
    3. Other health care utilization
- Family request for reassignment
- Enrollee or family perspectives of care, including compliance and grievance.
- Personnel/Provider satisfaction including turnover rates, physician disenrollment, and satisfaction with payment and authorization system.
- Medical record documentation

Enrollee Availability/Accessibility to Services:

CMSN - SFCCN providers are required to meet the following access to care standards:

- Emergency Medical Care - available 24 hours a day/7 days a week
- Urgent Care—within one day
- Routine Sick Care—within one week
- Well Care—within one month

The scope of the Quality Monitoring program incorporates:

- The generation of utilization reports for services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies, durable medical equipment companies, and pharmacies
- Facility audits and medical record reviews to monitor services provided by PCPs and high volume specialists
- Monitoring practice guidelines through medical record reviews and utilization reports
- The monitoring of high volume/high risk services based on review of demographic and epidemiological distribution of enrollees
- Services reflecting acute and chronic care
- Continuity and coordination of care
- Over and under utilization of medical resources
- Satisfaction surveys

- Complaint and grievance monitoring and analysis
- Compliance with practice guidelines including preventive health guidelines

After Hours Availability/ Call Coverage

- Access must be 24 hours a day/7 days a week
- After hours access must be with someone who is licensed to render a clinical decision
- After hours access does not include an answering machine unless it results in a prompt callback by a licensed clinician.

Re-credentialing Process

The DOH CMS Tallahassee Central Office will recredential providers at two to three year intervals. In addition to being in good standing with the Department of Health, the CMS Tallahassee Central Office credentialing process will review applicants for recredentialing using their achievement of quality indicators, compliance with medical record standards conformity to access and site maintenance standards, grievance and complaint trending, peer review outcomes, risk management profile, network redundancy and utilization management, management practices and compliance with the State of Florida diabetic care guidelines, National Asthma Guidelines, etc.

Medical Records Documentation

The following medical record standards apply to each enrollee's record:

- Must contain identifying information on the enrollee, including name, enrollee identification number, date of birth, sex, and legal guardianship
- Is legible and maintained in detail
- Contain a summary of significant surgical procedures, past and current diagnosis or problems, allergies, untoward reactions to drugs and current medication
- Entries are dated and signed
- Entries indicate the chief complaint or purpose of the visit; the objective findings of practitioner; diagnosis or medical impression
- Entries indicate studies ordered, and referrals to specialists for example: lab, x-ray, EKG, and referral reports
- Entries indicate therapies administered and prescribed
- all entries include the name and profession of practitioner rendering services, for example: M.D.,D.O., O.D., including signature or initials of practitioner
- Entries include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up, and outcome of services
- Contain an immunization history
- Contain information on smoking/ETOH substance abuse
- each record must contain a record of emergency care and hospital discharge summaries

Peer Review

It is the intention and purpose of the CMSN - SFCCN to continually improve the quality of the level of care and service provided to the CMS enrollee. The methodology to achieve this goal is based on establishing standards and performance goals for the delivery of care, services measuring performance outcomes and taking appropriate interventions to improve the outcomes. Clinical indicators called Generic Outcome Screen Indicators (GOSI), medical record standards and preventive health initiatives have been established and reviewed by a committee of physician providers. The GOSI will be utilized to review medical cases for the appropriateness of diagnosis and corresponding treatment, unexpected outcomes including mortality and morbidity, in addition to complications from surgery for both elective and emergent conditions. Enrollee satisfaction surveys; complaint and grievance monitoring and analysis; and finally, compliance with disease management program guidelines are reviewed along with the other standards previously mentioned and are used to access the performance of all primary care providers, including: Family Physicians, Internists, General Practitioners, Pediatricians, Obstetrician/Gynecologists and Advance Registered Nurse Practitioners (ARNP). Peer review responsibility resides in a committee or committees of licensed physicians who are members of the physician network of the CMSN - SFCCN. Responsibilities include:

1. Review of credentialing and re-credentialing applications
2. Conformance with the CMSN - SFCCN standards for availability and medical record keeping
3. Preventive care guideline compliance
4. Enrollee access to services
5. Validated enrollee complaints
6. Review outcomes that reflect unexpected or less than ideal results through GOSI

The ICS's intentions for unacceptable performance will increase in intrusiveness ranging from the tracking and trending of provider practices from the passive accumulation of data, suspension of additional assignment of enrollees, to the transfer of enrollees to another physician provider and/or the termination of privileges under the CMS contract. Whenever an action must be taken immediately in the best interest of patient care, a provider's contract can be summarily suspended.

A provider whose (1) Florida license, (2) DEA number, and (3) Medicaid/Medipass or (4) Medicare Provider numbers are revoked or suspended must **IMMEDIATELY** notify the ICS. The revocation or suspension of any of the above licenses or numbers will lead to an automatic suspension of the provider's CMS contract. The provider may re-apply to become a CMS provider, if and when, the revoked or suspended license or number is reinstated.

There will be a process in place that will offer the provider several levels of appeal within the ICS. The appellate process may be initiated by the provider contacting the Medical Director or Executive Director of the ICS. The final level of appeal will reside within the appellate system already in place in the ICS system. The CMSN - SFCCN will be responsible for reporting adverse peer review determinations to the National Practitioner's Data Bank that may have resulted in the loss of status in the ICS either on a temporary or on a permanent basis.

The CMS/DOH and/or the ICS, which will be providing oversight for this program, will be monitoring eleven (11) quality indicators that are clearly defined in the quality management section of this manual. The CMSN - SFCCN in turn will be closely monitoring these same indicators in evaluating the performance of primary care providers.

GENERIC OUTCOME SCREENING INDICATORS (GOSI)

(This information is confidential and proprietary in nature and for internal Quality Improvement purposes only

CRITERIA

1. **Unexpected admissions or complication of admission for adverse results of outpatient management. The following selected admission diagnoses could possibly be indicative of inadequate or inappropriate care in the ambulatory setting, such as:**
   - A. Diabetic Coma or Acidosis
   - B. Ruptured Appendix
   - C. Hypertensive Crisis
   - D. Bleeding or Perforation
   - E. Gangrene
   - F. Carcinoma of the Breast; Advanced (Primary)
   - G. Carcinoma of the Cervix
   - H. Drug Overdose/Toxicity/Sub-Therapeutic Drug Level(s)
   - I. Fracture Management; Adverse results of
   - J. Cellulitis/ Osteomyelitis
   - K. Bowel/Intestinal Obstruction
   - L. Bleeding Secondary to Anticoagulation
   - M. Electrolyte Imbalance
   - N. Septicemia
   - O. Pulmonary Emboli
   - P. Eclampsia/Pre-eclampsia
   - Q. Fetal Deaths
   - R. Thrombosis; Deep venous, on Oral Contraceptives
   - S. CVA/TIA
   - T. Dehydration
   - U. Carcinoma of the Colon; Advanced Primary
   - V. Carcinoma of the Lung-Advanced Primary
   - W. Airway Disorders including Croup, Asthma and Bronchitis
   - X. Gastroenteritis with Dehydration
   - Y. Nosocomial Infection
   - Z. Postpartum Complication
   - AA. Drug Reaction

2. **Unexpected Readmissions within 30 days of Discharge, such as:**
   - A. Post-op complication
   - B. Re-admission of the same problem/diagnosis

3. **Unplanned transfer from a low level of care (general care) to a higher level of care (intensive care)**

4. **Hospital Incurred Incidents, such as:**
   - A. Fall- with or without fracture, dislocation, laceration requiring suturing, concussion, loss of consciousness
   - B. Anesthesia complication(s)
   - C. Major preventative allergic reaction to drug
   - D. Transfusion error or life- threatening transfusion complication
   - E. Hospital acquired decubitus ulcer
   - F. Adverse drug reaction or complication from medication error:
   - G. Any hospital occurrence which could potentially require an incident report
   - H. Consent problems.

5. **Unplanned removal, injury and/or repair of an organ (or part of an organ) during an operative procedure or surgery performed on the wrong patient.**

CRITERIA

6. **An unplanned return for additional operative procedures, or an unplanned open surgery after closed or laparoscopic surgery.**

7. **Myocardial Infarction, such as:**
   A. During or within 48 hours of a surgical procedure on this admission.
   B. Death more than 24 hours after admission.
   C. Hemorrhagic complications prior to discharge or transfer for patients receiving thrombolytic therapy.

8. **Concurrent Intervention, such as:**
   A. Delay in seeing patient
   B. Inappropriate care, failure in ordering or requesting a consultation
   C. Inappropriate care relating to diagnosis
   D. Delay in surgical intervention

9. **Organ failure not present on admission (kidney, heart, lung, brain etc.)**

10. **Burn not present on admission, cast (pressure), chemical, electrical, or thermal**

11. **Drug/Antibiotic utilization which is unjustified, excessive, inaccurate, results in patient injury, or is otherwise at variance with professional staff criterion.**

12. **Unexpected abnormal laboratory, x-ray, other test results or physical findings not addressed by physician**

13. **Complication of Vascular Access Lines**
   A. Pneumothorax responding to rest or needle aspiration
   B. Pneumothorax requiring closed chest drainage or thoracotomy
   C. Pneumothorax requiring surgical intervention
   D. Complication of Hickman ports
   E. Dialysis ports removed/new ports
   F. Iatrogenic pneumothorax

14. **Obstetrical (OB) complications such as:**
   A. Pyemic embolism
   B. Pulmonary embolism
   C. Air embolism/Amniotic embolism
   D. Obstetrical shock
   E. Bleeding
   F. Abortions
      1. Cervical lacerations during first trimester abortion
      2. Pelvic infections following first trimester abortion
   G. Postpartum Infection
   H. Unexpected low Apgar score

15. **Delay or Missed Diagnosis**

16. **Access to care, such as:**
   A. Failure to obtain accepting physician(s)
   B. Long wait to get an appointment
   C. Failure in ordering or requesting a consultation
   D. Inadequate access to PCP
   E. Excessive/multiple emergency room usage
   F. Adverse effect of inadequate access to PCP

CRITERIA
17. **Quality of Care—Adverse or unexpected outcomes**
18. Performance of Medically Unnecessary Procedures
19. MRSA (in-patient diagnosis)
20. **Sentinel events, such as:** a) The death of a patient b) Brain or spinal damage to a patient c) The performance of a surgical procedure on the wrong patient, or d) The performance of a wrong –site surgical procedure e) The performance of a wrong surgical procedure f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition g) The 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 and documented through the informed-consent process h) The performance of procedures to remove unplanned foreign objects remaining from surgical procedure i) Infant abduction or discharge to the wrong family j) Suicide of patient k) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibility

-All GOSI will be evaluated as per CMSN - SFCCN and/or hospital system protocol, including reporting of Code 15 events to AHCA and review of JACHO sentinel events as related to accreditation requirements.