2020 Provider Handbook

Magellan Complete Care of Florida

Contents

About Magellan Complete Care

Magellan Complete Care is an integrated health plan designed for the total care of individuals, including medical and behavioral health needs. Our clinical and operational model of care allows us to offer our members access to high-quality, clinically appropriate, affordable healthcare tailored to each individual's needs with the ultimate goal of improved healthcare outcomes and overall quality of life for our members and their families.

Magellan Complete Care is a division of Magellan Health Services, a healthcare management company that focuses on fast-growing, complex and high-cost areas of healthcare, with an emphasis on special population management.

Model of Care

Our providers are the key to success in meeting the needs of our members. Our model is built to meet the medical and behavioral healthcare needs of our members. The level of support and coordination is dependent on the needs of the individual member. Our Care Coordination Team (CCT) deploys a broad set of tools, resources and reports. The CCT is comprised of the member and/or designated representative, PCP and specialists, a Magellan Complete Care Integrated Care Case Manager with both behavioral and physical health clinical expertise, peer support specialists, and a Health Guide. The Health Guide helps the member navigate the physical and behavioral health delivery systems and ensures the member receives all necessary services in order to live independently in the community.

Magellan Complete Care is a Medicaid specialty plan and is part of the Statewide Medicaid Managed Care program specializing in the care of those with Serious Mental Illness (SMI). Our members are eligible for Medicaid and have been diagnosed with a Serious Mental Illness.

Magellan Complete Care brings the same commitment to the provider community we have for the last 25-years. Together, we can leverage our strength, experience and expertise to improve outcomes for Medicaid recipients in our community.

Continuity of Care and Transition of Care Requirements

Magellan Complete Care and the other approved health plans follow special procedures during the transition period. The transition period is defined as the first sixty (60) calendar days from the date of the member's enrollment. Magellan works with in- and out-of-network providers to assure continuity of care:

- If the new member is receiving care which was authorized by their previous health plan or the member has ongoing treatment or medications, MCC will pay for those services even if the providers or the pharmacy are not in our network.
- Members can continue to see their PCP and behavioral health providers until the new PCP and BH providers have reviewed and updated the member's treatment plan (usually within 60 days).

Members considered high-risk if behavorial or physical care is disrupted are identified and prioritized. Our outreach program uses historical claims and service authorization data provided by the State or previous health plans.

If a member experiences a problem finding providers or getting an appointment, our care workers, health guides, and other staff will trouble-shoot in real time to ensure timely access to care.

Provider Services

Our Provider Support Representatives are committed to our providers and work to establish a positive experience with Magellan Complete Care including:

- Providing orientation to Magellan Complete Care network providers
- Providing education and support to facilitate best practices and cultural competency
- Implementing strategies related to the development and management of the Magellan Complete Care provider network
- Supporting the processes that lead to resolution of operational shortfalls (e.g. claims payment issues)
- Implementing provider practice-based quality initiatives (e.g. patient registries, P4P programs, provider scorecards)
- Distributing and reviewing various Magellan Complete Care reports

Statewide Medicaid Managed Care Program

Medicaid is the medical assistance program that provides access to healthcare for low-income families and individuals. Medicaid also assists the aged, blind and disabled with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the family's or individual's income and assets.

Florida has offered Medicaid services since 1970. Medicaid provides healthcare coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both state and federal governments. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services.

This program is referred to as statewide Medicaid managed care (SMMC) and includes two programs: one for medical assistance (MMA) and one for long-term care (LTC).
The Agency for Healthcare Administration (AHCA) is responsible for administering the Statewide Medicaid Managed Care program. Magellan Complete Care is a participating specialty plan in the SMMC program. Additional information regarding coverage and reimbursement can be found in the AHCA Medicaid handbook and fee schedules. This information is available at www.fdhc.state.fl.us/medicaid/index.shtml.

MCC Participation Requirements

All participating providers with Magellan Complete Care must have a unique Florida Medicaid Identification Number along with a National Provider Identification Number (NPI) and be credentialed by Magellan Complete Care. Magellan Complete Care does not employ or contract with individuals on the state or federal exclusions list.

Magellan Complete Care's Network Development department ensures that all services and tasks related to the provider contract are performed in compliance with the terms of the Provider Agreement. The provider contract identifies any aspect of service that may be subcontracted by the provider.

In general, Magellan Complete Care only contracts with participating providers in the Medicaid fee-for-service program. Thus, a Level II background screening is performed through this program. Background screening is conducted by Magellan Complete Care in the event that other providers are contracted.

In this event, the background screen will be a Level II

screening in accordance with Agency policies for providers not currently enrolled in the Medicaid fee-for-service program. This screening will require providers to submit fingerprints electronically through the Agency's system, allow Magellan to exclude from contracting any provider who has a record of illegal conduct, and permit Magellan to receive verification of Medicaid eligibility through the background screening website. Providers who have completed a background screen through the Medicaid program, or within the last 12 months by another Florida department, are exempt from this requirement.

Contact Telephone Numbers

To assist you with your day-to-day operations, Magellan Complete Care has a team of experienced Member Services, Provider Relations, Health Services and Pharmacy professionals to assist you with plan-related issues and questions. Please contact us whenever you need assistance.

Department	Hours (M – F unless noted)	Telephone
Provider Services Claims Network development (contracting) Credentialing Complaints	8 a.m. to 7 p.m. ET	1-800-327-8613 (TTY 711)
Pharmacy Benefits	8 a.m. to 7 p.m. ET 24 hours a day	1-800-327-8613 711, TTY only 24 hours a day (TTY 711)
Check Member Eligibility	24 hours a day	1-800-327-8613 (TTY 711)
Prior Authorizations and Referrals **Health Services (Utilization Management)**	24 hours a day	1-800-327-8613 (TTY 711)
Nurse Line	24 hours a day	1-800-327-8613 (TTY 711)
Member Services Behavioral health services Condition care programs Grievances and appeals	8 a.m. to 7 p.m. ET	1-800-327-8613 (TTY 711)
Vendor Contacts Non-emergent transportation (Veyo)	Reservation line: 8 a.m. to 5 p.m. ET Transportation assistance for trip recovery and after hour discharges is available 24/7/365	1-800-424-8268
Routine and preventive vision (Premiere Eye)	24 hours a day	1-800-738-1889
Hearing Evaluations (HearUSA)	8 a.m. to 8 p.m., voice mail after hours	1-800-528-3277
State Contacts FL Department of Children and Families	8 a.m. to 5 p.m. ET	1-866-762-2237

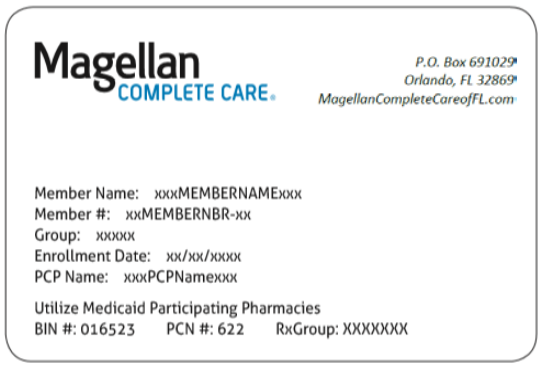
Member Eligibility and ID Card

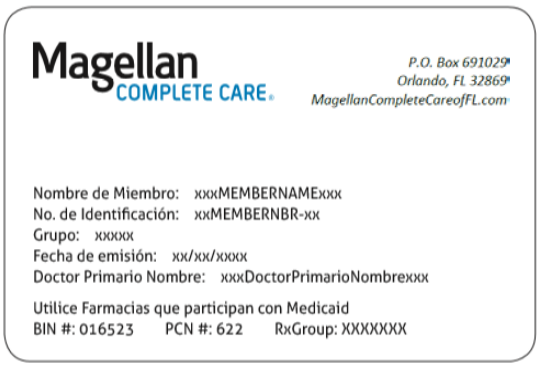
Magellan Complete Care requires members to keep their ID card with them at all times. If a member loses their ID card, please have them contact Member Services toll free at 1-800-327-8613. Hearing-impaired members should call TTY 711. Magellan Complete Care will send a replacement ID card within 5 business days.

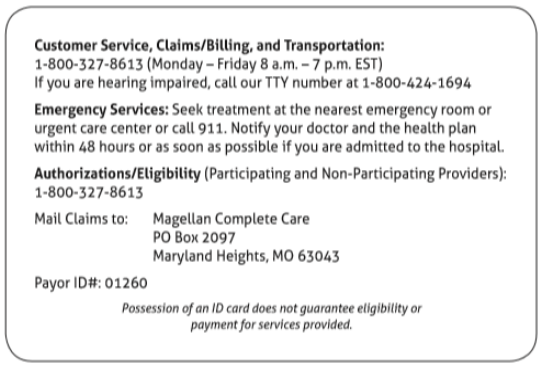
Please remember that a member ID card is not a guarantee of payment for services rendered. The provider's office is responsible for verifying eligibility at the time of each office visit. The provider can access the following methods to verify eligibility:

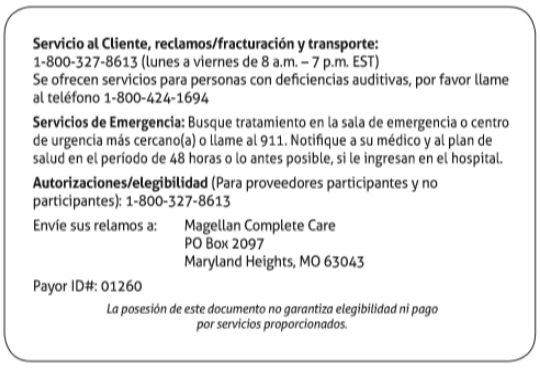
- Call 24-hour Eligibility Line at 1-800-327-8613
- Check online at MCCofFL.com

ID Card front:









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PCP Responsibilities

With the support of the Magellan Complete Care's Core Care team, the primary care provider (PCP) is responsible for the overall care of the member. This includes providing direct care; referring members for behavioral health, specialty or ancillary care; and coordinating care with the health plan and these providers for greater clinical outcomes.

Coordination of Care

- ***Coordinator of Care**:* The PCP is the coordinator of care. Therefore, the PCP agrees to ensure continuity of care for Magellan Complete Care's members and arranges for the provision of services when the PCP's office is not open. The PCP's integrated medical record should include documentation of the member's care and the treatment plan, including documentation of ER visits, lab results, hospital discharge summaries or operative reports.
- ***Sharing of Information**:* The PCP agrees to facilitate adequate and timely communication among providers and the transfer of information when members are transferred to other healthcare providers.
- ***Agency Communication**:* The PCP agrees to maintain communication with appropriate agencies, such as local police, social services agencies and poison control centers to provide quality care.
- ***OB/GYN as PCP**:* Each female member may select as her primary physician an obstetrician/ gynecologist who has agreed to serve as a primary physician and is in the Magellan Complete Care network. Please call Magellan Complete Care at 1-800-327-8613 if a member makes this request.

Access and Availability

***Member Panel**:* The PCP agrees to maintain a ratio of members to full time equivalent (FTE) physicians as follows:

- One physician shall not exceed a Magellan Complete Care member panel of 1,500; each physician extender (ARNP or PA) may increase panel size by 750 patients.
- The PCP must certify to Magellan Complete Care whether their active member panel exceeds 3,000 across all plans during the application and re-credentialing process.

Referrals

Consistent with our model of care, Magellan Complete Care has established a referral policy which promotes care coordination, integration, and access. We do not require in-network referrals to be approved by the health plan; however, provider records are expected to include evidence that care has been coordinated among the member's treating providers.

Specifically, PCPs should refer the member for specialty care and send their NPI number, clinical records and other relevant information to the specialist at the time of the referral, and in advance of the appointment. Specialists are expected to provide a written report to the PCP after seeing the member. All Magellan Complete Care providers are expected to maintain medical records which reflect this coordination. If coordination is oral, the providers' records should include documentation of the communication.

We require specialists to include the primary care provider's NPI number in field 17b on claims for office-based services. Exceptions to this requirement include:

- Provider is in the same provider group or has the same tax ID or type II NPI as the referring physician.
- Services were provided after hours (99050)
- Emergency services (services performed in place of service 23)

- Obstetrics/gynecology claims
- Billing or referring physician is from any of the following:
  - Federally Qualified Health Center
  - Urgent Care Center
  - County Health Departments
- Self-referrals—Members may self-refer for certain services, including:
  - Family planning services
  - Annual eye exams by optometrist
  - Some chiropractic, podiatric and dermatologic services
  - Well-woman examinations
  - Behavioral health services

For these excluded services, Magellan Complete Care requests your assistance in communicating and coordinating the care of members. However, we pay for direct-access services without completion of field 17b.

If medically necessary care cannot be provided by in-network providers, care can be provided by an out-of-network provider. In these exceptional cases, Magellan Complete Care requires prior authorization by the health plan.

Provision of Assessment and Counseling Services

- *Initial Assessment:* The PCP must conduct a health assessment of all new members within 90 days of the effective date of enrollment. The PCP is responsible for notifying Magellan Complete Care if unable to contact the member to arrange the initial assessment with 90 days.
- ***Members Entering Protective Custody****:* The PCP agrees to physically screen members taken into the Protective Custody, Emergency Shelter or Foster Care programs by the Department of Children and Families (DCF) within 72 hours or immediately, if required.

Provider Responsibilities (including PCPs)

Pregnancy

- ***Pregnancy Identification****:* The provider is responsible for notifying Magellan Complete Care's Health Services team at 1-800-327-8613 when they identify a pregnant member. If faxed, the notification should include the member's name, ID number, and due date.
- ***Referrals to Healthy Start and WIC****:* The provider agrees to refer pregnant women or infants to Healthy Start and WIC programs.
- ***HIV Counseling for Pregnant Women****:* The provider agrees to provide counseling and offer the recommended anti-retroviral regimen to all pregnant women who are HIV-positive and to refer them and their infants to Healthy Start programs, regardless of their screening scores.
- ***Hepatitis B Screening for Pregnant Women****:* The provider agrees to offer screening for Hepatitis B surface antigen to all women receiving prenatal care. If they test positive, the provider agrees to refer them to Healthy Start regardless of their screening score and to provide Hepatitis B Immune Globulin and the Hepatitis B vaccine series to children born to such mothers.

Access and Availability

- ***24-Hour Coverage****:* All providers must provide coverage 24 hours a day/seven days a week, and regular hours of operation must be clearly defined and communicated to members, including arranging for on-call and after-hours coverage. Such coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by Magellan Complete Care per AHCA guidelines. The after-hours coverage must be accessible using the medical office's daytime telephone number and the call must be returned within 30 minutes of initial contact.
- ***Coverage During Absence****:* The provider must arrange for coverage of services during absences due to vacation, illness, or other situations where the provider is unable to provide services. A Magellan Complete Care participating provider must provide coverage.
- ***Appointment Wait Time Requirement****:* The provider offers appointments to our members within the timeframes outlined below. Please ensure office staff is aware of and follows these standards. Magellan Complete Care audits its providers on a routine basis to ensure offices are compliant with this policy.
  - Urgent Care—within one day
  - Routine Sick Patient Care—within one week
  - Well Care Visit—within one month
- ***Timely Medical Evaluation****:* The provider will ensure that all patients have a professional evaluation within one hour of their scheduled appointment time. If a delay is unavoidable, the patient will be informed and provided an alternative.
- ***Americans with Disability Act****:* The provider agrees to establish appropriate policies and procedures to fulfill obligations under the Americans with Disabilities Act (ADA).

Member Dismissal

In certain circumstances, providers may find it necessary to dismiss a member from their practice and have them reassigned to a different provider. Reasons for dismissal must be documented by the provider and may include:

- Non-compliance with the provider's recommended plan of care.
- Excessive missed appointments, defined as three consecutive appointments within a six-month period.
- Disruptive, unruly, abusive or uncooperative behavior that seriously impairs the provider's ability to appropriately render services to the

member or other members. If the member's behavior is attributable to a mental health diagnoses, this section does not apply.

Prior to dismissing a member, the provider must make all efforts to remediate the relationship as appropriate. A provider may not request dismissal of a member to another provider because of the member's medical condition, the cost of care, or the frequency of care required by the member. A provider may only request that a member be dismissed if the member has had at least one (1) verbal warning and at least one (1) written warning including the full implications of his or her failure to comply.

All member notifications must be written at the fourth-grade reading level and must explain, in detail, the reason for dismissal from practice. All actions related to the request for dismissal must be clearly documented in the member's record. The documentation must include the reason for dismissal and all actions taken to attempt to remediate the relationship.

Providers must submit copies of medical records showing the reason for the dismissal and all actions taken to remediate to Magellan Complete Care of Florida (MCC of FL). Requests to dismiss a member for non-compliance or excessive missed appointments must be submitted at least sixty (60) calendar days prior to the requested effective date. Upon receipt of the request, MCC of FL will review the request and all required documentation, and make a determination on whether dismissal is appropriate. If MCC of FL deems the dismissal is appropriate, the plan will contact the member to assist with selecting a new PCP. If MCC of FL deems the dismissal is not appropriate, the plan will contact the member to provide further education on the consequences of behavior that is disruptive, unruly, abusive or uncooperative. Providers must continue to provide appropriate medical care to the member until the provider receives written notification from MCC of FL that the member has been dismissed from their practice.

Claims Submission

- To ensure timely payment, participating providers must submit clean claims and/or encounters using the methodology established by AHCA for that provider and service except as outlined in this manual. This also ensures the required Magellan Complete Care encounter data will be accepted by the Florida MMIS and/or State's encounter data warehouse.
- The provider agrees to submit a claim or encounter using the correct codes for each preventative visit. These claims provide the documentation needed for gaps in care for our members and for HEDIS (Health Plan Employer Data and Information Set) service.

Medical Records

- ***Participation in Medical Record Sharing:*** The provider must adhere to Magellan Complete Care's release of medical records policy to facilitate the sharing of medical records (subject to applicable confidentiality requirements in accordance with 42 CFR, Part 431, Subpart F, including a minor's consultation, examination and drugs for STDs in accordance with Section 384.30 (2), F.S.).
- ***Confidentiality of Member Records:*** The provider must comply with all applicable federal and state laws regarding the confidentiality of member records.
- ***Release of Medical Records:*** The provider agrees to obtain a signed and dated release allowing for the release of information to Magellan Complete Care and other providers involved in the member's care.
- ***Release of Information on Sensitive Conditions:*** Release of information about protected and sensitive conditions and services, including psychotherapeutic services, requires specific release from the member prior to sharing with other providers. The Magellan Complete Care Authorization to Use and Disclose Protected Health Information (AUD) form is used to indicate the conditions for which release is permitted. This form can be

found at MagellanCompleteCareofFL.com.

- ***Notations for Clinical Research**:* The provider agrees that any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of clinical research will be clearly contrasted with entries regarding the provision of non-research related care.
- ***Sharing of Immunization Information**:* The provider agrees to provide immunization information to the DCF upon receipt of member's written permission and DCF's request for temporary cash assistance from DCF on member's behalf.
- ***Obtaining Records from Out-of-Network Providers**:* The provider agrees to attempt to obtain medical records for any member(s) receiving services from a non-network provider using the proper release signed by the member.

See Medical Records section for additional information.

Network Development

- ***New Provider in Group Practice**:* If a new provider is added to a group, Magellan Complete Care must approve and credential the provider before the provider may treat members unless a prior authorization has been approved. Notification of changes in provider staff is the responsibility of the provider's office and must be communicated to Magellan Complete Care Network Development in writing to the following address:

  Network Management Contract Administration
  Florida MHS, Inc.
  14100 Magellan Plaza
  Maryland Heights, MO
  63043
- ***Malpractice Insurance**:* The provider is required to maintain malpractice insurance acceptable to Magellan Complete Care. This information is verified by obtaining a copy of the malpractice insurance fact sheet from the provider or from the malpractice insurance carrier. If the provider does not carry malpractice insurance ("going bare"), the provider must conform to the notification requirements contained in Section 458.320, F.S.

Credentialing

Providers are required to successfully complete the Magellan Complete Care credentialing process prior to seeing Magellan patients. As part of the credentialing and recredentialing process, Magellan Complete Care will identify, evaluate and verify provider education and experience through the primary source verification.

Providers must meet all Magellan Complete Care credentialing and recredentialing requirements, be aware of any applicable state licensing and credentialing laws and their malpractice policy regarding care for members residing in a different state or region. Providers should ensure the information provided through CAQH is updated in a timely manner and is current.

Providers have the right to review information submitted to support their credentialing application. Upon review of this information providers have the ability to correct any erroneous information. Providers have the right to receive status for their credentialing or recredentialing application upon written request.

Appealing Decisions That Affect Network Participation Status

Participating providers have a right to appeal Magellan Complete Care quality review actions that are based on issues of quality of care or service that impact the conditions of the provider's participation in the network. Client requirements and applicable federal and state laws may impact the appeals process; therefore, the process for appeals is outlined in the written notification that details changes in conditions of participation due to quality of care or service issues.

Magellan Complete Care in quality management activities, utilization review, continuing

Participating providers are offered an opportunity for a formal appeal hearing when Magellan Complete Care has taken action to terminate network participation due to quality concerns. These providers are notified of the action in writing. Notification includes: the reason(s) for the action; the right to request an appeal; the process to initiate an appeal; a summary of the appeal process; and that such request must be made within thirty-three (33) calendar days from the date of Magellan's written notification.

Providers may participate in the appeal hearing either telephonically or in person and may be represented by a person of their choice. Providers are notified in writing of the appeal decision within thirty (30) calendar days of completion of the formal appeal hearing. Specifics of the appeal and notification processes are subject to customer, state or Federal requirements.

Professional providers whose network participation is terminated due to license sanctions or disciplinary action, or exclusion from participation in Medicare, Medicaid or other Federal health care programs are offered an internal administrative review only, unless otherwise required by customer, state or Federal requirements. Providers are notified in writing of their network participation status, reason for denial of ongoing participation, and informed of their right to an internal administrative review. Providers are permitted no more than thirty-three (33) calendar days from the date of Magellan's written notification to request an administrative review if they disagree with the reasons for the termination. The provider is notified in writing of the outcome within thirty (30) calendar days of the administrative review.

Quality

- ***Quality Program Participation****:* The provider agrees to participate and cooperate with

peer review and other similar programs established by Magellan Complete Care to provide quality care in a responsible and cost-effective manner.

- ***Exposure Control Plan****:* The provider agrees to develop and maintain an exposure control plan that is compliant with OSHA standards regarding blood-borne pathogens.
- ***Minimizing Transmission of Infection****:* The provider agrees that provisions will be made to minimize sources and transmission of infection.
- ***Use and Exchange of Data****:* Providers agree to allow Magellan Complete Care to use all performance and claims data for reasons such as quality improvement activities. Magellan Complete Care will monitor the quality and performance of each provider using specific metrics. These metrics will be communicated to the network prior to implementation or changes. Magellan Complete Care will share appropriate data in support of these calculations with providers as appropriate and, from time to time, may request additional ad hoc data from providers to support these measures.
- ***Provide Care According to the most recent clinical practice guidelines for psychiatric, medical, surgical, mental health and substance abuse treatment****.* Providers must provide care based on most recent peer reviewed standards. These standards, with associated tip sheets, can be found on our provider portal and will be routinely updated per Magellan Complete Care guidelines. Refer to our website under https://www.magellancompletecareoffl.com/for-providers-2/provider-materials/*Participate in interdisciplinary care plan meeting:* It is the expectation that providers participate in these meetings in order review and discuss complex cases requiring coordination and targeted care planning. Attending these meetings is an important aspect of Magellan Complete Care's care coordination and case management functions.

Retrospective/Post Service Review Process

A retrospective/post-service request is defined as a request for coverage of medical care or services that has been received without an authorization on file. Retrospective decisions are made within 30 calendar days from receipt of the request and are based on the clinical information submitted at the time of the request.

Please note the following important information:

- Magellan Complete Care does not accept Retrospective/Post-Service review requests submitted directly to the Health Services (UM) Department without record of a previous claim denial.
- Hospitals are required to notify the plan of all emergency inpatient admissions within 24
- hours but no later than ten (10) days from date of admission. For notifications after ten (10) days from date of admissions for members who have already been discharged, hospitals must submit a claim with medical records. Once the claim with medical records has been received, the claim will be denied for no authorization and the medical records will be submitted to the Health Services Department to review for medical necessity. If the claim is submitted without medical records, the hospital must submit the medical records pursuant to the instructions on the EOP. In order to expedite this process, when submitting medical records after your claim has been denied, please submit a copy of your EOP or claim with your medical records.
- Non-hospital providers are expected to submit a pre-service authorization request to the plan prior to providing the service or care. For services that require an authorization, claims submitted for services provided without prior authorization will be denied.

Timeframes:

- Retrospective requests received within 35 days of the notification of claim determination (EOP) or as specified in contractual language: 30 days from receipt date.
- Retrospective requests received within 10 days of admission and no claim has been received: 7 days from receipt date.

In accordance with s.641.3155, F.S, medical records/retrospective review requests must be submitted by the provider within 35 days of the notification of claim determination (EOP), unless contractual language specifies a different timeframe.

True medical emergencies are the only exceptions where Magellan Complete Care of Florida will perform clinical reviews without the required prior authorization.

For emergency inpatient admissions no later than ten (10) calendar days from the date of admission in which services were provided and the member has already been discharged OR a claim denial for no authorization or requesting medical records has occurred (send a copy of claim EOP or claim denial) to:

Magellan Complete Care of Florida
Retrospective Review
PO Box 691029
Orlando, FL 32869

Or for emergency inpatient admissions that are greater than ten (10) calendar days from the date of admission and the member has already been discharged and no claim has been submitted, submit claim with medical records to:

Magellan Complete Care of Florida
Retrospective Review
PO Box 2097
Maryland Heights, MO 63043

Please call us at 1-800-327-8613 with any questions or concerns.

Grievances and Appeals

The provider agrees to participate in and cooperate with Magellan Complete Care grievance and appeal procedures when Magellan Complete Care notifies the provider of any member complaints or grievances. Refer to Grievances and Appeals section for more information.

Balance Billing

The provider cannot balance bill any member for a covered service. Magellan Complete Care is waiving member copays.

Provision of Assessment and Counseling Services

- HIV Counseling: The provider agrees to provide HIV counseling and offer HIV testing to all members of childbearing age.

Newborn Hearing Screening

Magellan Complete Care requires that all newborns receive a hearing screening from an audiologist per AHCA guidelines. All screenings must be completed prior to hospital discharge after birth unless appropriate communication has been provided to Magellan Complete Care. Follow-up visits should be scheduled, if necessary based on the results of the screening. The appropriate written documentation of service (or referral if necessary) must be placed in the recipient's medical record within 24 hours after the provider completes the screening procedure or within 24 hours of the parent's or guardian's signed refusal of screening. This information should be provided directly to the PCP as the coordinator of care.

The documentation must include the following:

- Type of screen test administered, date of test, and tester's name
- Results
- Interpretation
- Recommendations
- Follow-up referrals for treatment, if applicable
- Parent's or guardian's refusal of screening, if applicable

Identifying and Reporting Abuse, Neglect, or Exploitation

You can report abuse, neglect, or exploitation by calling the abuse hotline at 1-800-96-ABUSE. The Florida Abuse Hotline serves as the central reporting center for allegations of abuse, neglect, and/or exploitation for all children and vulnerable adults in Florida.

The Florida Abuse Hotline will accept a report when:

- There is reasonable cause to suspect that a child located in Florida, or is temporarily out of the state but expected to return in the immediate future, has been harmed or is believed to be threatened with harm from a person responsible for the care of the child; OR
- Any vulnerable adult who is a resident of Florida or currently located in Florida who is believed to have been abused or neglected by a caregiver in Florida, or suffering from the ill effects of neglect by self and is in need of service, or exploited by any person who stands in a position of trust or confidence, or any person who knows or should know that a vulnerable adult lacks capacity to consent and who contains or uses, or endeavors to obtain or use, their funds, assets or property. Abuse can be reported by calling the Florida Abuse Hotline, which is available statewide, toll-free telephone number, at 1-800 96-ABUSE (1-800-962-2873).

Marketing/Community Outreach Activities

Providers are required to comply with all state- and plan contract-related provisions and marketing requirements. The primary restrictions are summarized below.

To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice.
However, providers must remain neutral when assisting with enrollment decisions.

Providers may not:

a. Offer marketing/appointment forms.
b. Make phone calls or direct, urge or attempt to persuade recipients to enroll or disenroll in the Managed Care Plan based on financial or any other interests of the provider.
c. Mail marketing materials on behalf of the Managed Care Plan.
d. Offer anything of value to induce recipients/enrollees to select them as their provider.
e. Offer inducements to persuade recipients to enroll in the Managed Care Plan.
f. Conduct health screening as a marketing activity.
g. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
h. Distribute marketing materials within an exam room setting.
i. Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

Providers may:

a. Provide the names of the Managed Care Plans with which they participate.
b. Make available and/or distribute Managed Care Plan marketing materials.
c. Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.
d. Share information with patients from the Agency's website or CMS' website.

Provider Affiliation Information

a. Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).
b. Providers may make new affiliation announcements within the first thirty (30) calendar days of the new provider agreement.
c. Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.
d. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts.
e. Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.

Risk Management and Adverse/ Critical Incident Reporting

Risk management is a collaborative effort managed under the QI Program structure in conjunction with other Magellan Complete Care departments including Compliance and Legal. The goal of the program is early identification of potential or existing risk in order to eliminate or mitigate risks to members and Magellan Complete Care. To support this goal, the Risk Management Program incorporates the following components:

- A full-time employee designated Compliance Officer. The Compliance Officer is qualified by knowledge, training and experience in health care or risk management to promote, implement and oversee the compliance program.
- Investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to members.
- Development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including risk management and risk prevention education and training of personnel as follows:
  - Incorporated into initial orientation; and
  - A minimum of 1 hour of education and training annually for personnel of the organization who work in clinical departments and support care and services to members;
- Analysis of member grievances related to patient care and the quality of medical services; and
- Development and implementation of an incident reporting system based upon the affirmative duty of all providers and all agents and employees of the organization to report injuries and adverse incidents to the risk manager.
- Procedures and internal controls intended to reduce the frequency and severity of medical malpractice and patient injury claims.
- Training of employees and practitioners to report and file adverse incident reports with the Risk Manager to include reporting of incidents to the Risk Manager.
- Use of adverse incident reports to develop categories of incidents which identify problem areas.
- Processes to correct identified problem areas.
- Timely reporting to the Agency for Healthcare Administration of adverse incidents/untoward events which result in death of a patient, severe brain or spinal damage to a patient, a surgical procedure being performed on the wrong patient, or a surgical procedure unrelated to the patient's diagnosis on medical needs being performed on any patient.
- Provision of routine (at least quarterly) summary reports to the Magellan Complete Care governing board.

Adverse and Critical Incident Reports

Adverse incidents are unexpected occurrences in connection with services that led to or could have led to serious unintended or unexpected harm, loss or damage, such as death or serious injury, major medication incidents, exploitation, abuse, or neglect to an individual receiving service through Magellan Complete Care or a third party that becomes known to Magellan Complete Care staff .

Magellan Complete Care has developed and implemented an incident reporting and management system for adverse or critical incidents. This plan requires participating providers and direct service

providers to report adverse or critical incidents to Magellan Complete Care within 48 hours.

Magellan Complete Care does not require provider submission of adverse incident reports from the following providers: health maintenance organizations and health care clinics reporting in accordance with s. 64 .55, F.S.; ambulatory surgical centers and hospitals reporting in accordance with s. 395.0197, F.S.; assisted living facilities reporting in accordance with s. 429.23, F.; nursing facilities reporting in accordance with s. 400.147, F.S.; and crisis stabilization units, residential treatment centers for children and adolescents, and residential treatment facilities reporting in accordance with s. 394.459, F.S. Adverse incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.

When an adverse incident is identified, the provider completes the Magellan Complete Care Adverse Incident Report and mails it to the address indicated on the form or calls Magellan Complete Care's Health Services Risk Manager or Quality Department. If you call to report the information, please be prepared to provide all information listed on the form. Incidents related to (a) the death of a patient, (b) severe brain or spinal damage to a patient, (c) a surgical procedure being performed on the wrong patient, or permanent disfigurement, or (d) a surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient must be reported within 24 hours of the incident. All other incidents should be reported as soon as possible. A fracture or dislocation of bones or joints must be reported within **48 hours** of the incident or at the provider's knowledge of the incident.

Other reportable adverse incidents include any condition(s):

- Requiring medical attention which is not consistent with the routine management of the patient's case or pre-existing physical conditions,
- Requiring surgical intervention to correct or control,
- Resulting in transfer of the patient within or outside of the facility, to a unit providing a more acute level of care,
- Extending the patient's length of stay; or
- Resulting in a limitation of neurological, physical or sensory function which continues after discharge from a facility.

Magellan Complete Care provides appropriate training and takes corrective action as needed to ensure its staff, participating providers, and direct service providers comply with critical incident reporting requirements.

As part of this plan, Magellan Complete Care will report to the Department of Children and Families' Central Abuse Hotline any suspected cases of abuse, neglect or exploitation of enrollees, in accordance with s.39.201 and Chapter 415, F.S. Magellan Complete Care maintains documentation related to the reporting of such events in a confidential file, separate from the enrollee's case file. Such file shall be made available to the Agency upon request.

Magellan Complete care reports a summary of adverse and critical incidents to the Agency, as specified in Section XIV, Reporting Requirements, in the manner and format determined by the Agency.

Fraud, Waste and Abuse Responsibilities

Magellan Complete Care does not tolerate fraud, waste or abuse, either by providers or staff. Accordingly, we have instituted extensive fraud, waste and abuse programs to combat these problems. Magellan Complete Care's programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, waste and abuse in government programs and private insurance.

Magellan Complete Care's expectation is that the provider will fully cooperate and participate with its fraud, waste and abuse programs. This includes but is not limited to, permitting Magellan Complete Care access to member treatment records and allowing Magellan Complete Care to conduct on-site audits or reviews. Magellan Complete Care also may interview members as part of an investigation, without provider interference.

Our policies in this area reflect that both Magellan Complete Care and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs (e.g., Medicare and Medicaid), federally funded contracts and private insurance. Magellan Complete Care complies with all applicable laws, including the Federal False Claims Act, state false claims laws (see state-specific information on our website), applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded programs (e g., Medicare Advantage, SCHIP and Medicaid) and other payers. Visit our website to review these policies at https://www.magellancompletecareoffl.com/for-providers-2/working-with-mcc/

The provider's responsibility is to:

- Comply with all laws and Magellan Complete Care requirements
- Comply with all federal and state laws regarding fraud, waste and abuse
- Provide and bill only for medically necessary services that are delivered to members in accordance with Magellan's policies and procedures and applicable regulations
- Ensure that all claims submissions are accurate
- Notify Magellan Complete Care immediately of any suspension, revocation, condition, limitation, qualification or other restriction on the provider's license, or upon initiation of any investigation or action that could reasonably lead to a restriction on the provider's license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services

Definitions—Fraud, Waste and Abuse

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to federally and/ or state-funded healthcare programs and other payers.

Waste means over-utilization of services or other practices that result in unnecessary costs.

Some examples of potential fraud, waste and abuse include:

- Billing for services or procedures that have not been performed or have been performed by others
- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., upcoding to increase reimbursement)
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion)
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act
- Providing or ordering medically unnecessary services and tests based on financial gain
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day (e.g., a psychiatrist billing individual therapy and pharmacological management on the same day for the same patient)
- An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day (e.g., a social worker billing two individual psychotherapy sessions on the same day for the same patient)
- Providing services over the telephone or Internet and billing using face-to-face codes
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session)
- Treating all patients weekly regardless of medical necessity
- Routinely maxing out members' benefits or authorizations regardless of whether the services are medically necessary
- Inserting a diagnosis code not obtained from a physician or other authorized individual
- Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals)
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs
- Lying about credentials, such as degree and licensure information.

Report Suspected Fraud, Waste or Abuse

Magellan Complete Care expects providers and their staff and agents to report any suspected cases of fraud, waste or abuse. Magellan Complete Care will not retaliate against the provider if he/she informs Magellan, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

Reports of fraud, abuse or waste should be made to Magellan Complete Care via one of the following methods:

- National Special Investigations Unit Hotline: 1-800-755-0850
- Florida Special Investigation Unit Hotline: 1-877-269-7624

- Special Investigations Unit Email: SIU@MagellanHealth.com
- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

You can also report suspected cases of fraud, waste, abuse, and overpayments directly to the agencies listed below:

- Bureau of Medicaid Program Integrity—To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline tollfree at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx
- Florida Office of the Attorney General Medicaid Fraud Control Unit at 1-866-966-7226—If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other healthcare provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free: 1-866-966-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.
- Florida Department of Financial Services Division of Insurance Fraud: Contact the DFS Fraud Hotline at 1-800- 378-0445
- U.S. Department of Health & Human Services Office of Inspector General: Contact the Office of the Inspector General by phone, fax, email, or by mail.

  U.S. Department of Health & Human Services
  Office of Inspector General
  ATTN: OIG HOTLINE OPERATIONS
  PO Box 23489
  Washington, DC 20026
  Telephone: 1-800-HHS-TIPS (1-800-447-8477)
  Fax: 1-800-223-8164
  Email: HHSTips@oig.hhs.gov

Presence on Federal and State Exclusions List

Consistent with federal and state requirements, any individual or entity excluded from participation in federally or state-funded contracts and programs cannot participate in any federally or state-funded healthcare program. Magellan Complete Care's policy is to ensure excluded individuals/entities are not hired, employed or contracted by Magellan Complete Care to provide services for any of Magellan's product offerings.

The provider's responsibilities as required by the Centers for Medicare and Medicaid Services (CMS), further protects against payments for items and services furnished or ordered by excluded parties. If the provider participates in federally funded healthcare programs, he/she must take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- Screen all employees, agents and contractors to determine whether any of them have been excluded. Providers are required to comply with this obligation as a condition of enrollment as a Medicare or Medicaid provider.
- Search the HHS-OIG LEIE website at www.oig.hhs.gov/to capture exclusions and reinstatements that have occurred since the last search. Providers can search the website by individual or entity name.
- Immediately report to the respective state Medicaid Agency and Magellan Complete Care any exclusion information discovered.

To comply with Magellan Complete Care's fraud, waste and abuse programs, the provider's responsibility is to:

- Prior to contracting/hiring, and monthly thereafter, check to ensure the provider, your employees, agents, directors, officers, partners or owners/person with a five percent or more controlling interest and subcontractors are not debarred, suspended, terminated or otherwise excluded under the HHS-OIG LEIE at http://www.oig.hhs.gov/, the General Services Administration's System for Award Management (SAM) Exclusions Database (http://www.sam.gov/), the Florida Sanctioned and Terminated Provider List (https://apps.ahca.myflorida.com/dm_web), and any other applicable state exclusion list where the services are rendered or delivered, and immediately notify Magellan Complete Care in writing of the debarment, suspension or exclusion of the provider, the provider's employees, agents, subcontractors, directors, officers, partners or owners with a five percent or more controlling interest.
- Disclosure Requirements: Medicaid providers are required to disclose information regarding:
  - the identity of all individuals and entities with an ownership or control interest of 5 percent or greater in the provider including information about the provider's agents and managing employees in compliance with 42 CFR 455 .104
  - certain business transactions between the provider and subcontractors/wholly owned suppliers in compliance with 42 CFR 455 .105

- the identity of any individual or entity with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider group or entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs in compliance with 42 CFR 455.106

Remember—Magellan Complete Care has a non-retaliation policy.

Magellan Complete Care will not retaliate against you or any of its employees, agents and contractors for reporting suspected cases of fraud, waste, or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits Magellan Complete Care from discriminating against an employee in the terms or conditions of their employment because the employee initiated or otherwise assisted in a false claims action.

Magellan Complete Care also is prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.

Magellan's responsibility is to implement and regularly conduct fraud, waste and abuse prevention activities that include:

- Extensively monitoring and auditing provider utilization and claims to detect fraud, waste and abuse
- Actively investigating and pursuing fraud and abuse and other alleged illegal, unethical or unprofessional conduct
- Reporting suspected fraud, waste and abuse and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations
- Cooperating with law enforcement authorities in the prosecution of healthcare and insurance fraud cases
- Verifying eligibility for members and providers
- Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded healthcare programs
- Training employees annually on Magellan's Corporate Compliance Handbook
- Making the Magellan Complete Care Provider Handbook available to network providers

Cultural Competency Plan

All Magellan Complete Care members should be treated with dignity and respect by the provider and their staff. Magellan providers are prohibited from discriminating against different types of patients based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, source of payment or health status.

Magellan Complete Care has implemented a comprehensive cultural competency plan to improve our members' health outcomes and quality of care, and to reduce disparities in racial and ethnic healthcare. The plan follows The National Standards on Culturally and Linguistically Appropriate Services (CLAS) to educate our employees, members and providers on the importance of communication in a preferred language and respect for cultural health beliefs. These standards are also used to inform members about their rights to receive effective, understandable, and respectful care that is provided in a manner in which their cultural health beliefs are in their preferred language. To receive a full copy, at no cost, of the Magellan Complete Care Cultural Competency Plan, please visit our website MagellanCompleteCareofFL.com or send your request in writing to:

Magellan Complete Care
Attn: Provider Services
P.O. Box 691029
Orlando, FL 32869

To receive training for you and/or your staff, please call Provider Services at 1-800-327-8613.

Magellan Complete Care provides educational and informational materials about our plan in English and Spanish and in other languages on request. Member Services can provide written materials such as large print, audio tape or Braille (for the blind) upon request.

Interpreter services for all languages including sign language are provided free for our members. Magellan Complete Care has a telephone language line available 24 hours a day, seven days a week.

We are also able to provide on-site translators through Global Interpreting. Call Member Services for more information and to schedule.

Magellan Complete Care provides community- based medical linkage that supports racial and ethnic minorities and the disabled to ensure community resources are accessible to members with special needs.

The provider has the following responsibilities related to Cultural Competency:

- ***Non-Discrimination****:* The provider agrees to practice in their profession ethically and legally, provide all services in a culturally competent manner, accommodate those with disabilities and not discriminate against anyone based on their health status.
- ***Interpretive Services****:* The provider agrees to contact Magellan Complete Care for assistance with interpretive services when no one in their medical office is able to communicate with a member in their primary language.
- ***Objection on Religious Grounds****:* The provider agrees to inform Magellan Complete Care if they object to the provision of any counseling, treatments or referral services on religious grounds.

Member Rights and Responsibilities

Key provider responsibilities related to Member Rights and Responsibilities are:

- ***Treatment of Member****:* The provider agrees to treat all members with respect and dignity, to provide them with appropriate privacy and to treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release in accordance with HIPAA and applicable state laws.
- ***Disclosure of Information to Member****:* The provider agrees to provide to the member complete information concerning their diagnosis, evaluation, treatment and prognosis, and to give member the opportunity to participate in decisions involving their healthcare, regardless of whether the member has completed an advance directive, except when contraindicated for medical reasons.
- ***Florida Bill of Rights****:* Magellan Complete Care has adopted the Florida member's Bill of Rights and Responsibilities. All providers should have a copy of this document in their office.

Members have the right to:

- Be treated with courtesy and respect
- Have their dignity and privacy considered and respected at all times
- Receive a prompt response to questions and requests
- Receive information about Magellan Complete Care, its services, its practitioners and providers, and its member rights and responsibilities
- Know who is providing their medical services and care
- Know what services are available. This includes if they need an interpreter because they don't speak English
- Know what rules and regulations apply to their conduct
- Be given the truth about their health status
- Refuse any treatment, except as otherwise provided by law
- Participate with practitioners in decisions about their care.
- Be given full information and counseling on the availability of known financial resources for their care
- Know whether the healthcare provider or facility accepts the Magellan's contract rates
- Receive, prior to treatment, a reasonable estimate of cost
- Receive a copy of an itemized bill. If the member wants to have the charges explained, the provider must do so.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- Know if medical treatment is for purpose of experimental research. If it is, then member can refuse or accept the services
- Express complaints regarding any violation of the member's rights
- Appeal MCC of FL's decision about services and file grievance, voice complaints about any matter other than decisions about services
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand
- A right to a discussion of appropriate or treatment options of conditions, regardless of cost or benefit coverage.

- To make suggestions about MCC of FL's member rights and responsibilities policy
- 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
- Be furnished healthcare services in accordance with federal and state regulations

A member is responsible for:

- Giving the provider accurate information about their past and present health status
- Reporting unexpected changes in their health status
- Talking to the provider to make sure they understand health conditions, participate in developing a course of action and what is expected, to the degree possible
- Following the treatment plan they have agreed to and recommended by the provider
- Keeping doctor appointments
- Notifying the provider they cannot come to the appointment
- Knowing what will happen to them if they ignore the provider's treatment plan
- Making sure financial responsibilities are met
- Following the provider's conduct rules and 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.

Magellan Complete Care is in charge of making sure they get the amounts owed by all members. This is decided by the Florida Department of Children and Families (DCF).

Magellan Complete Care has rules and processes in place to make sure members are charged and pay the amounts they owe. Some members may not owe fees. This may happen because of their low income. It can also happen because of the means that were used to decide on the amount owed.

Patient Responsibility to Residential Providers

Magellan Complete Care can give the task of gathering its members' fees to the residential providers and pay the residential providers a net of the fee amount. If Magellan Complete Care lets the residential provider collect the fees, the residential provider contract will give full details of both groups' duties on getting the members' fees. Magellan Complete Care can either gather the members' fees from all of its providers or give the collection to all of its residential providers.

Provider Complaints

The Managed Care Plan's process for provider complaints concerning claims issues will be in accordance with s.641.3155, F.S.

For provider complaints concerning non-claims issues, the Managed Care Plan will:

- Allow providers forty-five (45) days to file a written complaint for issues that are not about claims
- Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution
- Document why a complaint is unresolved after fifteen (15) days of receipt and provide written notice of the status to the provider every fifteen (15) days thereafter
- Resolve all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

There are three types of provider complaints with different filing requirements:

1. Policy-Related Complaints

All complaints disputing the policies and procedures or any aspect of the administrative functions of Magellan Complete Care can be oral or written. The complaint must be filed no later than 45 calendar days from the date the provider becomes aware of the issue generating the complaint. Provider policy-related complaints may be filed in writing to:

Magellan Complete Care
Attn: Complaint Coordinator P.O. Box 691029
Orlando, FL 32869
FLMCCQI@MagellanCompleteCare.com

2. Utilization Management-Related Complaints

Providers have 45 days from the date on the notice of the original utilization management decision to file a complaint regarding the utilization management decision process.

However, in order to submit a provider dispute/appeal regarding an adverse benefit determination, a provider must comply with the adverse benefit determination which states that for a provider to dispute, the dispute must be filed within 30 days from the date that is on the notice. Members have 60 days to appeal. These timeframes should not be confused, and for the provider dispute/appeal to be considered timely, the required summary and the medical records must be received by the health plan on the 30th day.

The summary must be one of the following:

- A detailed cover letter to include the items specified in the Provider Appeals form. The cover letter must identify why the medical records were sent, as well as a clinical summary of the provider's rebuttal with references to national criteria such as Interqual and/or MCG Guidelines®
- A complete and detailed Provider Appeals form (additional pages can be attached).

The decision on the dispute will be based entirely on the submitted medical records. Magellan Complete Care will not request additional records or information to evaluate the complaint.

There are no second level considerations for cases that are denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may submit proof. Acceptable proof of timely filing must only be in the form of a registered postal receipt signed by a representative of Magellan or similar receipt from other commercial delivery services. Magellan will respond to the provider's request for review.

Magellan Complete Care Attn: Complaint Coordinator
P.O. Box 691029
Orlando, FL 32869
FLMCCQI@MagellanCompleteCare.com

3. Claims-Related Disputes:

Providers have from the following timeframes to file a provider complaint or submit additional information or documentation:

- In network providers—90 days
- Out of network providers—365 days

Complaints filed after that time will be denied for untimely filing.

There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may submit proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Magellan or similar receipt from other commercial delivery services. Magellan will respond to the provider's request for review.

Examples of claims disputes include but are not limited to:

- Paid incorrectly—under or over paid
- Missing mandatory fields
- Diagnosis is not billable with CPT code

Claims denials for no authorization on file or clinical department denials are processed in accordance with the retrospective review or provider dispute/appeals process.

For denials involving the denial code of "max 45 inpatient benefit limit reached" or "medical records request for PPC" (Provider Preventable Condition); these are handled and processed through the appeals department and no timeframes are associated with these submissions.

All complaints concerning claims payment issues must be filed in writing.

If the provider complaint regarding claims payment requires review for medical necessity as in a retrospective review or provider dispute/appeal, all medical records and supporting documentation necessary for the review should be sent in accordance with the timeframes associated with same. The decision on the complaint where there is a medical necessity determination made, will be based entirely on the submitted medical records—Magellan Complete Care will not request additional records or information to evaluate the complaint.

Magellan Complete Care
Attn: Complaint Coordinator
P.O. Box 691029
Orlando, FL 32869

FLMCCQI@MagellanCompleteCare.com

A provider may also contact Provider Services at 1-800-327-8613 where dedicated staff is available to answer questions, assist in filing a provider complaint and resolve any issues. They are available anytime between 8 a.m. and 7 p.m. Eastern time, Monday through Friday excluding state holidays, or leave a message after hours that will be returned on the next business day.

Provider Complaint Process

Magellan Complete Care will review the complaint for medical necessity and conformity to plan guidelines and contractual obligations. During this time, Magellan Complete Care may request additional information from the provider in order to complete a review of the complaint. At the conclusion of the review, the provider will receive a written decision with an explanation for the decision.

All provider complaints will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying Magellan Complete Care written policies and procedures.

Magellan Complete Care will also ensure that the appropriate decision makers with the authority to implement corrective action are involved in the provider complaint process. Magellan Complete Care shall provide a written notice of the outcome of the review to the provider.

External Claims Dispute Process

Statewide Provider and Health Plan Claim Dispute Resolution Program: The Agency for Health Care Administration (AHCA) has contracted with MAXIMUS, an independent dispute resolution organization, to provide assistance to health care providers and health plans for resolving claim disputes. Claim disputes must have been submitted by the provider or the health plan, and they must have been denied in full or in part or presumed to have been underpaid or overpaid. Application forms and instructions on how to file claims are available from MAXIMUS directly at 1-866-763-6395. Ask for *Florida Provider Appeals Process.*

Please contact Maximus to determine if your claims dispute is eligible for review.

Magellan Complete Care is not responsible for payment for medical records generated as a result of a provider complaint or for records requested for the investigation of critical incidents, utilization review or quality of care reviews.

Any invoices received by Magellan Complete Care for such charges will be redirected to the provider. Complaints received without the necessary documentation will be denied for lack of information and the provider will be notified.

Member Grievance and Appeals

Definitions

Complaint: A member complaint is any expression of dissatisfaction by a member and must be resolved by Magellan Complete Care within one business day. If not, this complaint will become a grievance.

Grievance: A grievance is a formal complaint from a member, or designee on their behalf, about a provider or service. This must be resolved by Magellan Complete Care within 90 days. The member will receive an adverse benefit determination from Magellan Complete Care.

Appeal: An appeal is a formal request from a member, their authorized representative, or their legal representative of the estate about a service that is denied. This is not for provider's acting on their own behalf to resolve adverse benefit determinations made by Utilization Management.

Those acting on behalf of the member must provide the member's (written) consent except when the member is in acute inpatient facility. An appeal can be filed orally or in writing. If the appeal is oral, it must be followed up in writing within 10 days. Member appeals must be made within 60 days from the date on the adverse benefit determination from Magellan and will be resolved by Magellan Complete Care within 30 days of receipt for standard appeals. The member will receive an adverse benefit determination from Magellan Complete Care.

If the member (or their authorized representative) needs help with filing a grievance or appeal, please call Grievance and Appeals toll free at 1-800-327-8613. Our Grievance and Appeals department is available from 8 a.m. – 7 p.m. Monday – Friday.

Please mail the member's grievance or appeal to:
Magellan Complete Care
Attn: Complaint Coordinator
P.O. Box 691029
Orlando, FL 32869

Authorized Representative: An individual who has the legal authority to make decisions on behalf of an enrollee or potential enrollee in matters related to the Managed Care Plan.

Expedited Appeal: If a member's health is in danger and an expedited review is required, please let Magellan Complete Care know it's urgent. Magellan Complete Care will make a decision within 48 hours of receipt.

During the process, the member can continue to receive care at no cost. However, if the final decision is not in their favor, they may have to pay for the care.

If a member (or their provider on their behalf) needs help with filing an expedited grievance or appeal, please call Grievance and Appeals toll free at 1-800-327-8613. Please remember to tell Magellan Complete Care it is urgent. Our Grievance and Appeals department is available from 8 a.m. – 7 p.m. Monday – Friday.

Please mail your grievance or appeal to:

Magellan Complete Care
Attn: Complaint Coordinator
P.O. Box 691029
Orlando, FL 32869

Medicaid Fair Hearing

If a member or their authorized representative does not agree with Magellan's decision regarding their grievance or appeal, they or their authorized representative can request a Medicaid Fair Hearing (within 120 days from the date on the plan appeal resolution notice).

Per Florida Administrative Code 65-2.045(3) Hearings Request: A Request for Hearing may be made by the applicant/recipient or someone on their behalf. However, if the appeal is filed by someone other than the applicant/recipient, attorney, legal guardian, spouse, next of kin, the grantee relative in cash assistance, or a person allowed by the Department as an authorized representative to participate in the eligibility determination, the person making the appeal must have the written authorization of the applicant/recipient.

To request a fair hearing, notification should be mailed to the address below or the member should contact the agency directly at:

Agency for Health Care Administration Medicaid
Hearing Unit
PO Box 60127
Ft. Myers, FL 33906
1-877-254-1055 (toll-free)
FAX: 239-338-2642

EMAIL:MedicaidHearingUnit@ahca.myflorida.com

Medical Management

Medical Necessity Standards

Magellan's Medical Necessity Criteria (MNC), which is based on current scientific evidence and clinical consensus, are used in making medical necessity determinations. We review the criteria annually, taking into consideration current scientific evidence and provider feedback, and revise them as needed. We also align these criteria with the Agency for Healthcare Administration's medical necessity standards and practice protocols. Magellan Complete Care has adopted MCG *Guidelines®* for the management of Medical and Behavioral Health services. We have also developed and maintain proprietary clinical criteria as well as the Magellan Complete Care Behavioral Health Care Guidelines, for specialty behavioral outpatient services and Florida Medicaid specific services. These criteria are made available to any interested party on the MCCofFL.com website or by hard copy upon request by calling Member Services at 1-800-327-8613.

In accordance with 59G-1.010 Florida Administrative Code, services that include medical or allied care, goods, or services furnished or ordered must be provided under the following conditions:

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

Medical necessity for those services furnished in a hospital on an inpatient basis must be (1) consistent with the provisions of appropriate medical care and (2) effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

It is important to remember that:

- UM decision making is based only on appropriateness of care and service, and existence of coverage.
- Magellan Complete Care does not reward practitioners or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
- Practitioners may freely communicate with members about their treatment, regardless of benefit coverage.

Treatment Adherence

Magellan Complete Care of Florida has medication and treatment adherence programs available to help ensure that members continue in care and obtain maximum benefit from their care.

Through interdisciplinary meetings and treatment planning, we work in collaboration and coordination with our providers to establish and monitor treatment plans that are targeted and tailored to each member. Through our health guides, peer support specialist and care managers we reach out to members, provide them with the support they need to address barriers influencing their ability to obtain care and also aid in transitions of care that can be difficult to navigate. At each step we rely on the collaboration with our network providers to develop treatment adherence strategies that work for our members.

Mental Health and Substance Abuse Assessments

Magellan Complete Care's plan preference is for providers to use the following assessments:

- CAGE-AID for substance abuse
- AUDIT (Alcohol Use Disorders Identification Test)
- DAST-10 (drug Abuse Screen Test)
- PHQ 9 for depression
- Mental Health Screening Form III

Magellan Complete Care recognizes that there are additional tools for the assessment of substance abuse and mental health and will support the use of other peer reviewed and validated instruments.

Continuity of Care

Magellan Complete Care will allow members in active treatment to continue to receive care from their current provider for the first 60 calendar days with our plan. After the 60 days pass, Magellan Complete Care will work closely with the member and the non-par provider to determine continuation of care by the non-par provider. Magellan Complete Care will only authorize treatment in special cases.

Prior Authorization

Prior authorization must be requested for some services through Magellan's Health Services department, which is available 24 hours a day, 7 days a week. Providers are expected to submit a pre-service authorization request to the Plan prior to providing the service or care. For services that require an authorization, claims submitted for services provided without prior authorization will be denied. Please call us or use the electronic request process at MagellanCompleteCareofFL.com. You may also utilize the prior authorization forms found on MagellanCompleteCareofFL.com.

Members may seek behavioral health services without the referral of the Primary Care Provider. Magellan Complete Care Integrated Case Managers and Health Guides will work collaboratively with members and their Primary Care Providers in order to ensure that all care and services are coordinated and integrated into the member's comprehensive treatment plan.

Services that require a prior authorization rendered without prior authorization will be denied for payment.

Magellan Complete Care may allow a standing authorization to be approved for members with chronic or disabling conditions. Providers should specifically request these authorizations when working with Magellan Complete Care case and disease managers on care plans for their patients.

Decisions on routine prior authorizations will be rendered within seven (7) calendar days. Decisions on expedited prior authorization requests will be rendered within 48 hours, if Magellan determines the request qualifies for expedited consideration. The provider will be notified if the request will not be considered as an expedited request.

Decisions for approved services are based only on appropriateness of care and service and existence of coverage. Utilization Management staff and Medical Directors are not financially or otherwise compensated to encourage underutilization and/or denials.

The following services do not require prior authorization from Magellan. This list is subject to

change. A complete list can be found at www.MagellanCompleteCareofFL.com. Notifications of changes will also be sent via provider bulletin.

- Emergency services
- Post stabilization services or other post stabilization care as identified under 42 CFR 422.113©
- Some chiropractic services at a participating provider
- Annual eye exam at a participating optometrist
- Some podiatric services at a participating provider
- Dermatology services up to 5-times per year with no referral from a participating provider
- Family planning services may be obtained from any Medicaid provider without prior authorization
- Annual well woman exam at a participating provider and follow-up care as needed
- Diagnosis and treatment of sexually transmitted disease when provided at the Community Health Department
- Routine outpatient behavioral health services such as evaluations, medication management, individual and/or family therapy

If members receive care from out-of-network providers without prior authorization, Magellan Complete Care will not pay for this care. PCPs should contact Magellan Complete Care if they wish to request an exceptional referral for the member to see an out-of-network provider. If an out-of-network provider provides emergency care, the service will be paid for.

Peer to Peer Process

MCC of FL's Physician Reviewers may contact providers prior to rendering a decision. If an adverse decision has been made, MCC of FL uses a peer-to-peer review process where a Physician Reviewer re-examines a case regarding health care services for the member. This process allows attending, treating or ordering providers to request a peer-to-peer review, offer additional information and further discuss the cases with a Physician Reviewer.

Please note: A peer to peer review is not an appeal, nor does it take the place of an appeal. In addition, a peer-to-peer review is not required prior to requesting an appeal. In order to prevent unnecessary peer-to-peer reviews, please provide ample clinical information to support the member's condition.

How to initiate the peer-to-peer review process

We will accept your request to initiate a peer-to-peer review within five (5) business days from the date that you receive the adverse benefit determination notification. You may initiate the peer-to-peer review process by contacting MCC of FL. In order to schedule a peer-to-peer review, MCC of FL must have already received the additional clinical documentation that will be used during the peer-to-peer discussion with a Physician Reviewer.

Peer-to-peer review guidelines

In compliance with nationally recognized guidelines from the National Committee for Quality Assurance (NCQA), providers may request a peer-to-peer review. You can initiate a peer-to-peer review request if the caller is the attending, treating or ordering physician who provides the care for which any adverse benefit determination is made. Other callers, such as hospital representatives, third party representatives, and

vendors, are not permitted to do so. Individuals who are not health care professionals on the clinical team are prohibited from participating in the peer-to-peer discussion.

Availability of clinical peer reviewers – If the Physician Reviewer who made the initial adverse benefit determination is unavailable, another Physician Reviewer will be assigned to the case.

Our commitment to contacting providers: Within one (1) business day of receiving the peer-to-peer review request after you've submitted the clinical submission for the peer-to-peer review, MCC of FL will make three (3) attempts to obtain provider availability if not initially provided. The Physician Reviewer will make at least two (2) attempts to contact the attending, treating or ordering provider. We will work to accommodate the attending, treating or ordering provider's schedule within normal business hours for that provider's time zone.

Covered Service

Limits and prior authorizations exist for some of these services and these benefits are subject to change. Please contact us to confirm benefit information. Visit our website at MCCofFL.com for more details.

Services

Advanced Registered Nurse Practitioner Services

Ambulatory Surgical Center Services

Birth Center Services

Child Health Check-Up Services

Chiropractic Services

Community Behavioral Health Services

County Health Department Services Crisis Help

Durable Medical Equipment / Medical Supplies Dialysis Services

Emergency Room Services Family Planning Services

Federally Qualified Health Center Services Hearing Services

Home Healthcare Services and Private Duty Nursing Care

Hospice

Hospital Services—Inpatient

Hospital Services—Outpatient

Immunizations—Childhood

Independent Laboratory Services

Licensed Midwife Services

Mental Health Counseling

Nursing Facility Services

OB Services

Optometric Services

Physician Services

Physician Assistant Services

Podiatry Services

Portable X-Ray Services

Prescribed Drugs (including Behavioral Health)

Preventative Services—e.g. CHCUP, Well Woman Exams, Mammograms

Primary Care Case Management

Services Radiology Services

Rural Health Clinic Services

Substance Abuse Support

Targeted Case Management

Therapeutic Group Care (TGC)

Therapy Services (Occupational, Physical, Respiratory, and Speech)

Transplant Services

Transportation Services

Vision Services

Magellan Complete Care Extended Services

Service	Benefit	Authorization required?
Collaborative Care	Unlimited	No
Circumcision (newborns only)	One per lifetime for infants up to 28 days old	No
Chiropractic Services	Unlimited	Yes - after meeting Medicaid limitations
Behavioral Health Assessment/Evaluation Services	Unlimited	No
Behavioral Health Day Services/Day Treatment	Unlimited behavioral health day treatment	Yes
Behavioral Health Medical Services (e.g. medication management, drug screening, etc.)	Unlimited verbal interaction (mental health and substance abuse), medication management, and drug screening	No
Behavioral Health Psychosocial Rehabilitation	Unlimited when meeting medical necessity criteria	Yes
Behavioral Health Screening Services	Unlimited	No
Behavioral Health Group Therapy	Unlimited group therapy and brief medical group therapy	No
Hearing Services	The following services are provided 1 per every 2 years: assessment for hearing aids, hearing aid fitting/checking, hearing aid monaural in ear, behind ear hearing aid, hearing aid dispensing fee, in ear binaural hearing aid, behind ear binaural hearing aid, dispensing fee, behind ear cros hearing aid, cros hearing aid dispensing fee, behind ear bicros hearing aid, dispensing fee bicros, and hearing evaluation	Yes
Individual/Family Therapy	For individual and family therapy, unlimited for brief individual psychotherapy	Yes – after 104 units/year
Home Health Visits—enhanced for non-pregnant adults	Can exceed 3 visits per day when medically necessary	Yes
Intensive Outpatient Therapy Services	No limits when medically necessary	Yes
Primary Care Visits—enhanced for non-pregnant adults	Unlimited outpatient visits	No

Service	Benefit	Authorization required?
Respiratory Services	One initial evaluation and one re-evaluation per year; one respiratory therapy visit per day	Yes
Speech Therapy	One evaluation and re-evaluation per year; one evaluation of oral and pharyngeal swallowing function per year; up to 7 therapy treatment units per week; one AAC initial evaluation and one AAC re-evaluation per year; up to four 30-minute AAC fitting, adjustment, and training sessions per year	Yes
Substance Abuse Treatment or Detoxification Services (Outpatient)	Unlimited	Yes
Vaccines—adults	Pneumonia – unlimited	Yes
	Shingles one (1) shot; one per year lifetime	Yes
	TDaP – One (1) vaccine per pregnancy	No
	Influenza – Unlimited Flu shot one per year for members 19 and over	No
	Hepatitis A – Two (2) per enrollee	No
Copays	Waived Providers are not permitted to charge copays for any covered service for Magellan Complete Care members.	No

Additional Notes for Covered Services

Service	Benefit	Authorization required?
Diabetes Care	We cover all needed equipment, supplies, and services to treat diabetes, including self- management training and educational services if ordered by your doctor.	No
Family Planning Services	May get services from any participating Medicaid provider	No
Inpatient Hospital Services	Members over the age of 21 are limited to 45 days per Medicaid fiscal year There is no limit for members under the age of 21 or for emergency care and pregnant adults.	Yes
Nursing Facility Services	Magellan Complete Care will furnish nursing facility services to members under the age of eighteen (18) years. For nursing facility contracts for services to members under the age of eighteen (18) years, the nursing facility provider must notify the Department of Children and Families.	Yes
Nursing Facility Admissions	Nursing facility providers must submit a completed DCF #2506A Form (Client Referral/Change) to the Department of Children and Families (DCF) within ten (10) business days of the admission to a nursing facility of an MMA enrollee under the age of eighteen (18) years.	Yes
Nursing Facility Discharges	The nursing facility providers must submit a completed DCF #2506 Form (Client Discharge/Change Notice) to the Department of Children and Families (DCF) within ten (10) business days of the discharge from a nursing facility of a member under the age of eighteen (18) years	Yes
Outpatient Services	There is no limit for members under the age of 21.	Yes
Physician Services	May be given by individuals who are not licensed physicians, including nurse practitioners and physician assistants, when under the direction of your PCP Limited to one visit per day unless for an emergency, one new patient evaluation, one long term care facility visit per month	No
Therapeutic Group Care	Therapeutic group care services or specialized therapeutic group care are community-based, psychiatric residential treatment services designed for recipients under the age of 21 years with moderate to severe emotional disturbances. They are provided in a licensed residential group home setting serving no more than 12 recipients. Providers must comply with the regulations and requirements listed in the Specialized Therapeutic Services Coverage and Limitations Handbook. A copy of the authorization form for this service can be found in our website under the provider authorization forms section	Yes

Service	Benefit	Authorization required?
	https://www.magellancompletecareoffl.com/for-providers-2/forms/	
Women's Health	A female member, without approval from her PCP, may visit a contracted obstetrician/gynecologist (OB/GYN) for one annual visit and for medically necessary follow-up care as a result of that visit.	No
Prescribed Drugs	Limits on quantity, day supply, age, and number of fills may apply and are set by Florida Medicaid. For drugs not on the Preferred Drug List (PDL), there is a step therapy requirement for trial and failure of two (2) preferred drugs with exceptions.	Yes – for non-PDL drugs and select PDL drugs

Magellan Complete Care In lieu of Services

Magellan Complete Care will provide any of the following in lieu of services to enrollees when it is determined to be medically appropriate and in accordance with the requirements for the provision of in lieu of services contained in this contract, after obtaining approval from the Agency.

Service	Benefit	Authorization required?
Crisis stabilization units (CSU)	MCC clinical team uses MCG *Guidelines*® to determine that the member continues meeting the acute inpatient level of care.	Yes
Detoxification or addictions receiving facilities licensed under s.397,F.S.	MCC clinical team uses MCG *Guidelines*® to determine that the member continues meeting the acute inpatient level of care.	Yes
Mobile crisis	Mobile crisis services should not be considered when a serious medical need exists, for example, in the event of a lethal overdose	No
Ambulatory detoxification services	Service includes clinical and medical management of the physical and psychological process of withdrawal from alcohol and other drugs on an outpatient basis in a community-based setting	No
Partial hospitalization services	MCC clinical team uses MCG *Guidelines*® to determine that the member continues meeting the acute inpatient level of care.	Yes
Self-Help/Peer Services	May be used in lieu of Psychosocial Rehabilitation services intensive services.	No

Subcontractors and Inter-Company Partners with Magellan Complete Care

Magellan Complete Care works with the following partners and sub-contractors to coordinate and manage the following covered services below:

Contracted Entity	Services Provided	Entity Type	Authorization required?
Magellan Rx Management	Specialty Pharmacy	Subcontractor	Yes – for non-PDL drugs and select PDL drugs
Magellan Rx Management	Mail Order Pharmacy	Subcontractor	Yes– for non-PDL drugs and select PDL drugs
Magellan Rx Management	Pharmacy Benefit Management	Subcontractor	Yes – for non-PDL drugs and select PDL drugs
NIA	Advanced Radiology	Inter-company partner	Yes
Premiere Eye	Vision, routine and preventative	Subcontractor with UM delegation	Yes
Veyo	Transportation, non-emergency	Subcontractor	Advanced reservations required
Coastal Care Services	Home Health / Home Infusion Therapy / DME	Subcontractor	Yes
HearUSA	Audiology, hearing evaluations. Hearing aids through Magellan Complete Care.	Subcontractor	No

Waived Copayments & Fees

In accordance with the American Recovery and Reinvestment Act of 2009; Magellan Complete Care will not impose enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider, Indian Health Service, an Indian Tribe, Tribal Organization, an Urban Indian Organization or through referral under contract health services.

Second Medical Opinion

Members have the right to a second medical opinion. If the organization cannot provide for a second opinion from an in-network provider, arrangements can be made for a second opinion outside the network. Please contact our Health Services department at 1-800-327-8613 for a prior authorization request.

Emergency Services

Providers are required to ensure adequate accessibility for healthcare twenty-four (24) hours per day, seven days per week. In cases of an emergency, the member should go to the closest emergency room or any other emergency setting. An emergency is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, including a pregnant woman or a fetus, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In addition, an emergency, with respect to a pregnant woman, is also defined as situations where there is inadequate time to effect safe transfer to another hospital prior to delivery, a transfer may pose a threat to the health and safety of the patient or fetus, or there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Members are encouraged to contact their PCP as soon as possible when they are in a hospital or have received emergency care.

The facility is required to notify Magellan Complete Care within 24 hours when a member accesses the facility.

If the emergency room doctor treating the member states to the member that the visit is not an emergency, the member will be given the choice to stay and get medical treatment or follow up with their primary care physician. If the member decides to stay and receive treatment and it has been determined that the care is not deemed medically necessary, the services will be denied and will not be a covered benefit.

If the member is treated for an emergency, and the treating doctor recommends treatment after the member is stabilized, the member will be encouraged to call their Magellan Complete Care PCP.

Magellan Complete Care does not deny claims for emergency services and care received at a Hospital due to lack of parental consent. In addition, Magellan Complete Care does not deny claims for treatment obtained when a primary care physician or a representative of Magellan Complete Care instructs the member to seek Emergency Services and Care.

Magellan or the provider affiliated with the plan will not:

- Require prior authorization for a member to receive pre-hospital transport or treatment or for emergency services and care

- Specify or imply that emergency services and care are covered by Magellan only if secured within a certain time period
- Use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered
- Deny payment based on a failure by the member or the hospital to notify Magellan before, or within a certain time period after emergency services and care were given

Magellan covers any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as Magellan can safely transport the member to a participating facility. Magellan may transfer the member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the member’s emergency medical condition. The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

Magellan will not deny claims for the provision of emergency services and care submitted by a nonparticipating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 365 days.

Emergency Ambulance Services

Magellan reimburses for emergency transportation (ALS or BLS) by ambulance, whether ground or air. Emergency transportation does not require prior authorization.

Codes for Emergency Ambulance Services:

A0429 Ambulance Service, Basic Life Support
A0427 Ambulance Service, Advanced Life Support
A0433 Advanced Life Support, Level 2 (ALS2)
A0434 Specialty Care Transport (SCT)
A0999 Negotiated Transportation Services for Mileage

Mileage is not reimbursed unless the member is transported outside of the county. If the recipient is transported out of the county in which the recipient was picked up, provider will be reimbursed $3.00 per mile plus the base rate. This rate begins at the point of pick-up.

Out of Area Emergency Services

If the member is away from home and has an emergency, they are instructed to go to the nearest emergency room or any emergency setting of their choice. In such situations, the member should call their PCP as soon as possible.

Well child visits/Vaccines

Magellan promotes wellness visits for all their members. Well child visits are an integral part of our wellness program. Magellan Complete Care of Florida will reach out to the parents of newly enrolled infants and children to determine the date of the last well child visit and to parents of existing members with a gap in care to schedule a PCP visit. These visits include comprehensive health and developmental history (including assessment of past medical history, developmental history and behavioral health status) for eligible children birth through 20 years old:

- Comprehensive unclothed physical examination
- Developmental assessment
- Nutritional assessment

- Appropriate immunizations according to the appropriate recommended childhood immunization schedule for the united states
- Laboratory testing (including blood lead testing)
- Health education (including anticipatory guidance)
- Vision screening, including objective testing as required
- Hearing screening, including objective testing, as required
- Diagnosis and treatment, and referral and follow-up as appropriate

Magellan members under the age of 21, should have their well child check-up visits at:

- Birth
- 2-4 days for newborns discharged less than 48 hours after delivery
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Once every year for ages 3-20

Additional well child visits can be requested at other times if the guardian feels it is needed. Magellan Complete Care provides transportation to and from visits as needed through Veyo.

In addition, the provider has responsibilities regarding the administration of vaccines:

- ***Participation in Immunization Registry****:* The PCP is encouraged to participate with Florida's Immunization Registry (SHOTS).
- ***Tracking and Administration of Vaccines****:* The PCP agrees to maintain vaccines safely, in adequate supply, and in accordance with specific guidelines, to provide member immunizations according to professional standards and to maintain up-to-date member immunization records.
- ***Vaccines for Children****:* The PCP for Medicaid members must use their Vaccines for Children Program (VFC) supply. The VFC program covers children from birth to 18 years of age. Florida Medicaid requires vaccines for Medicaid children from birth through 20 years of age. Members 19 through 20 years of age should receive their vaccinations from their PCP and will be reimbursed at the applicable Medicaid rate.
- ***Blood Lead Screening****:* Providers are also required to screen all enrolled children for lead poisoning at ages 12 months and 24 months. In addition, children between the ages of 12 months and 72 months must receive a screening blood lead test if there is no record of a previous test. Magellan Complete Care provides additional diagnostic and treatment services determined to be medically necessary to a child/adolescent diagnosed with an elevated blood lead level. Paper filter tests are recommended as part of the lead screening requirement, but not required. Magellan Complete Care will provide case management follow-up services for children with abnormal blood lead screenings.

For an authorization of a medically necessary service that is needed for members under the age of twenty-one (21) years in circumstances where The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule, is not a covered service of the plan, or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or corresponding fee schedule, the medically necessary service will be reviewed by a Medical Director. Both the member and the requesting provider will be notified of the determination once the request has been approved and authorized.

Telemedicine

Magellan Complete Care supports the use of telemedicine. Providers interested in providing telemedicine services should contact their provider contracting rep to add the appropriate addenda to their contract. The contract documents will spell out requirements and rates for telehealth, and training will be scheduled. At a minimum, the requirements for providers participating in Magellan's telemedicine program include:

- Interactive and real-time synchronized multimedia (audio and video) transmission. Remote camera control is preferred. The provider must have a dedicated secure line and utilize an acceptable method of encryption.
- The originating site (location of the member) must have telehealth support staff able to assist the member with the technical equipment and connection. A protocol must be in place to access emergent or urgent clinical care if the designated telehealth support staff are not clinicians. The member site should be a room that provides privacy.
- Providers should have completed basic training on telehealth equipment, provide the same rights to confidentiality and security of clinical information as provided in face-to-face services, and must include in the member's clinical record that the service was provided via telehealth.

All records must contain documentation to include the following items for services provided through telemedicine:

- A brief explanation of the use of telemedicine in each progress note
- Documentation of telemedicine equipment used for the specific covered services provided
- A signed statement from the enrollee or the enrollee's authorized representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided

If the provider has been approved by the Managed Care Plan to provide services through telemedicine, the provider is required to have protocols to prevent fraud and abuse. The provider must implement telemedicine fraud and abuse protocols that address:

- Authentication and authorization of users
- Authentication of the origin of the information
- The prevention of unauthorized access to the system or information
- System security, including the integrity of information that is collected, program integrity and system integrity
- Maintenance of documentation about system and information usage

Community Referrals

Magellan Complete Care would like to assist you when the need for a referral for other services is identified. Magellan Complete Care has relationships and linkage agreements with community providers that offer services that complement the traditional benefits covered by the plan. These relationships allow us to collaborate with agencies that offer important ancillary services such as emergency shelter, housing, home-delivered meals, and emergency childcare. We would like for you to call us if one of our members needs referrals of any kind. We would like to make sure we have the opportunity to be a partner to you. Magellan Complete Care counts on a large network of both providers and community contacts which we can access to meet our members' needs. Additional information and referrals to service either covered through the plan or ancillary community services may be accessed by calling us at 1-800-327-8613.

Covered Pharmacy Services

Prescription drug benefits are managed though Magellan Complete Care and are administered by Magellan Complete Care's prescription benefits manager, Magellan Pharmacy Solutions. Magellan Complete Care uses a Preferred Drug List (PDL). This is a list of prescription drugs approved by Magellan Complete Care for use by our members. All generic drugs and certain brand name drugs listed in the PDL are covered. Some drugs, even though they are listed on the PDL, may have special limitations such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first.

Non PDL drugs may be requested through the Prior Authorization process. Some drugs are excluded from the pharmacy benefits such as those for weight loss, infertility and cosmetic purposes. The PDL is available to providers on the Magellan Complete Care website at: MagellanCompleteCareofFL.com/fl-site/providers/preferred-drug-list/preferred-drug-list.

Pharmacy Policy

Magellan Complete Care's pharmacy benefit provides access to a broad range of approved medications using a preferred drug list (PDL). The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the physician or pharmacist
- Relieve the physician or pharmacist of any obligation to the patient or others

Generic substitution may be mandatory when a generic equivalent is available. The mandatory generic substitution provision is waived for drugs that have a narrow therapeutic index such as warfarin, levothyroxine, digoxin and cyclosporine.

Magellan Complete Care of Florida's Preferred Drugs List is aligned with Florida Medicaid's Preferred Drug List, which is created and maintained by the Pharmacy and Therapeutics Committee who meets quarterly. To view the Preferred Drug List posted on the state agency's website as well as a summary of limitations, visit: https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml.

Rx Prior Authorization

The PDL attempts to provide appropriate and cost-effective drug therapy to all participants covered by the Magellan Complete Care pharmacy program. If a patient requires medication that does not appear on the PDL, the physician can make a request for a non-preferred medication. It is anticipated that such expectations will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. In order for a member to receive coverage for a medication requiring prior authorization, the physician or pharmacist must submit a Prior Authorization Request Form, located at www.MCCofFL.com, and include all relevant clinical information and previous drug history. Return the form by mail, fax or electronically to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street,
Suite 500 Glen Allen, VA 23060
Phone: 1-800-327-8613
TTY: 711
Fax: 1-800-424-7982

Electronic Rx Prior Authorization Requests

Providers can register at https://account.covermymeds.com/signup or call 1-866-452-5017 for assistance. All Rx prior authorization requests (standard and expedited) regarding prescription drugs, will be responded to within 24 hours via telephone or fax. Turnaround time on decisions may be extended if there is missing clinical documentation.

Prior Authorization form(s) can be found at: https://www.magellancompletecareoffl.com/for-providers-2/forms/ . Providers are expected to submit a pre-service authorization request to the plan prior to providing the service or care. For services that require an authorization, claims submitted for services provided without prior authorization will be denied.

Rx Prior Authorization Criteria

Coverage determinations for prescription drug prior authorization requests are based on clinical drug criteria created by Florida Medicaid. For your reference, this criteria is located at https://ahca.myflorida.com/medicaid/PrescribedDrugs/drug_criteria.shtml.

Over-the-Counter Items

Over-the-counter items may be a covered benefit for some members. The Magellan Complete Care PDL covers several over-the-counter (OTC) medications and supplies. Over-the-counter items will not require a prescription and can be obtained at the store level. Magellan Complete Care will impose a limit of $25/month for OTC medications. Visit www.MCCofFL.com for more information.

72-Hour Emergency Supply Policy

All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of non-PDL drugs (non-preferred drugs).

The following drug categories are not part of the Magellan Complete Care preferred drug list and **are not covered by the 72-hour emergency supply policy:**

- Anorectics: Drugs used for weight loss (unless prescribed for an indication other than obesity).
- Anti-Hemophilia Products (Billed as Fee-for-Service to Florida Medicaid)

- Cough and Cold Medications for members ages 21 and over
- DESI ineffective drugs as designated by CMS
- Drugs used to treat infertility.
- Experimental/Investigational pharmaceuticals or products
- Erectile dysfunction products prescribed to treat impotence
- Hair growth restorers and other drugs used for cosmetic purposes
- Immunizing agents (except for influenza vaccine)
- Injectable/Oral drugs administered by the provider in the office, in an outpatient clinic or and infusion center, or in a mental health center
- Prostheses, appliances and devices (except products for Diabetics and products used for contraception)
- Injectable drugs or infusion therapy and supplies (except those listed in the PDL)
- Nutritional supplements
- Oral vitamins and minerals (except those listed in the PDL)
- OTC drugs (except those listed in the PDL)
- Drugs covered under Medicare Part B and/or Medicare Part D

Newly Approved Products

Newly approved drug products will not normally be placed on the preferred drug list during their first six months on the market. During this period, access to these medications will be considered through the PA review process.

Care and Disease Management Programs

Please call our Care and Disease Management department toll free at 1-800-327-8613 to enroll your patient, our member. Magellan has programs that will help members more effectively self-manage their chronic diseases. Some of the programs we offer are:

- Complex Case Management
- Asthma
- Hypertension
- Diabetes
- Cancer
- High Risk Maternity

Quality Benefit Enhancement Programs

Quality Benefit programs help our members to better their total health. Magellan partners with local community agencies to support:

- Domestic Violence Prevention
- Children's Programs
- Pregnancy Programs
- Pregnancy Prevention Programs
- Behavioral Health Programs
- Stop Smoking
- Substance Abuse Support

Please call our Provider Relations department toll free at 1-800-327-8613 for more information. They can assist with providing literature to your office for our members.

Member Rewards Program

Magellan Complete Care wants to encourage our members to make healthy choices and participate in activities that will help them be healthy and keep them from getting sick. As a Magellan Complete Care member, they are eligible for Member Rewards if they take part in specific activities. The goal is to reward their healthy behavior.

Members will receive information on how to earn Member Rewards from their Care Coordination Team. If they leave Magellan Complete Care, rewards cannot be transferred to another health plan. They will lose access to earned rewards if they voluntarily disenroll from Magellan Complete Care or lose Medicaid eligibility for more than one-hundred eighty (180) calendar days. For more information, you or the member can call Magellan Complete Care at 1-800-327-8613.

Continuity of Care Procedures Upon Provider Termination

Magellan Complete Care will notify members within 60 days of the effective date of provider termination without cause. This will include all members who are in a course of active treatment with the provider, assigned to the provider as PCP, or has prior authorized care with the provider.

Magellan Complete Care will allow the members in active treatment to continue to receive care from the provider until the course of treatment is completed, another provider is selected, or during the next open enrollment period—not to exceed 6 months after the termination date. Pregnant members are permitted to continue the course of treatment until completion of postpartum care. If providers are terminated for cause, notification will occur as soon as practicable (not to exceed 5 business days, but immediately if the member is in imminent danger) and the following continuity of care provisions do not apply.

A terminated provider can refuse to provide care to a member who is abusive or noncompliant. All services provided under the continuity of care provisions will be reimbursed at the rates included in the last active contract.

Medical Records Standards

All Magellan Providers must maintain Medical Records for each member in accordance with the standards as listed below as appropriate. Provider to include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases etc.

1. Include the member's identifying information, including name, member identification number, date of birth, sex, and legal guardianship (if any).
2. Each record must be legible and maintained in detail.
3. Providers must ensure a method for obtaining complete and current patient clinical information and maintaining an updated summary. For example, history and physical form, summary sheet, or checklist. All records must include the history/physical completed including history of procedures and diagnoses.
4. Treatment plans shall reflect evidence-based standards of care and be consistent with the diagnosis for each visit.
5. Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications.
6. All entries must be dated and signed by the appropriate party.
7. All entries must indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider.
8. All entries must indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports.
9. All entries must indicate therapies administered and prescribed.
10. All entries must include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider. All notes written by physician extenders (ARNPs or PAs) must be co-signed by the assigned PCP, indicating their review and approval of the care rendered.
11. All entries must include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up and outcome of services.
12. All records must contain an immunization history.
13. All records must contain information relating to the member's use of tobacco products and alcohol/substance abuse.
14. All records must contain summaries of all Emergency Services and care and hospital discharges with appropriate medically indicated follow up.
15. Documentation of referral services must be in member's Medical Records. This is to include but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases.
16. All records must reflect the primary language spoken by the member and any interpretive needs of the member.
17. All records must identify members needing communication assistance in the delivery of healthcare services.
18. All records must contain documentation that the member was provided with written information concerning the member's rights regarding Advance Directives (written instructions for living will or power of attorney) and whether the member has executed an Advance Directive. Providers cannot, as a condition of treatment, require the member to execute or waive an Advance Directive.
19. Copies of any advance directives executed by the member.
20. Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of 13 (thirteen).
21. Example of the Magellan Medical Record Review Form is available in the Forms section of this Provider Manual.

22. Example of the Magellan Medical Record Review Form is available in the Forms section of this Provider Manual.
23. Provider shall prepare, maintain, and dispose all appropriate medical, administrative, and financial records covering healthcare services provided to each member pursuant to the State and Federal laws.
24. Provider shall document follow-up care and record results of studies and therapies and appropriate follow-up according to Magellan Complete Care policies.

Medical Record Retrieval

Providers will, upon request of the patient or patient representative, furnish without delays for legal review, copies of all reports and records relating to examination or treatment, including x-rays, and insurance information. However, when a patient's psychiatric, chapter 490 psychological or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the healthcare practitioner may provide a report of examination and treatment in lieu of copies of records. Upon the patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered.

Medical Record Confidentiality

Confidentiality of Medical Records Providers will ensure the confidentiality of all medical records in accordance with 42 CFR, Part 431, Subpart F and relevant HIPAA requirements. The confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease must be maintained in accordance withs 384.30(2), F.S.

Medical Record Review

Magellan Complete Care will audit medical records to determine adherence with Magellan Complete Care standards for documentation and AHCA regulations. Audits will be performed at a minimum of every three years for PCPs that serve ten (10) or more members. Behavioral Health provider's clinical records will be audited as well. We will also conduct medical record audits on high volume and high impact specialty providers such as OB/GYN, Cardiology and Oncology among others.

Readmission Policy

Following hospitalization, a readmission is often a costly preventable event and a potential quality of care issue. Readmissions can be a result of many situations, but most often are due to the lack of transition of care from one setting to the next or discharge planning. A readmission review is important to ensure that our members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations. However, there are some readmissions that are unavoidable due to the inevitable progression of the disease state or to chronic conditions.

Readmission reviews will be conducted in accordance with CMS instructions which states "Perform case review on both stays. Analyze the cases specifically to determine whether the patient was prematurely discharged from the first confinement, thus causing readmission. Perform an analysis of the stay at the first hospital to determine the cause(s) and extent of any problem(s) (e.g., incomplete, or substandard treatment). Consider the information available to the attending physician who discharged the patient from the first confinement. Do not base a determination of a premature discharge on information that the physician or provider could not have known or events that could not have been anticipated at the time of discharge."

Reimbursement for readmissions will be limited to the payment for the first admission and the second payment will be denied within the 30 day qualification, unless it meets one of the exceptions noted below, violates State and/or Federal law or violates the terms of the hospital or Provider Services agreement between the hospital and MCC of FL. If the readmission occurs at a different facility, the second admission will be reimbursed and the payments to the first facility will not be eligible for payment due to readmission unless the case meets one of the exceptions noted below, and/or violates the terms of the hospital or Provider Services agreement between the hospital and MCC of FL.

Exceptions

- The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission
- The readmission is part of the medically necessary, prior authorized or staged treatment plan
- There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.
- Admissions for cancer or chemotherapy treatment as the principal condition.

Definitions

Clinically Related Readmission Chain: A series of admissions for the same patient where the underlying reason for readmission is related to the care rendered during or within thirty days following a prior hospital admission. A clinically related readmission may have resulted from improper or incomplete care during the initial admission or discharge planning process. The hospital where the initial admission occurred is responsible for the clinically related readmission chain. Hospitalization resulting from an unpreventable or unrelated event occurring after discharge and planned readmissions are not considered clinically related.

Diagnosis-related Groups (DRG): A patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives.

Planned Readmission: A non-acute admission for a scheduled procedure for limited types of care for example: obstetrical delivery, transplant surgery and maintenance chemotherapy/radiotherapy/immunotherapy.

Potentially Preventable Readmission (PPR): A readmission within a specific time frame that is clinically related and may have been prevented had appropriate care been provided during the initial hospital stay and discharge process. A PPR is determined when a patient was discharged prematurely. Premature discharge evidence can be described as, but not limited to, elevated fever at the time of discharge, abnormal lab results or evidence of infection or bleeding a wound.

Prospective Payment System (PPS): A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a specific service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).

Readmission: A subsequent inpatient admission to an acute care facility which occurs within a certain amount of days based on the State and Federal guidelines from the discharge date; excluding planned admissions.

Same or Similar Condition: A condition or diagnosis that is the same or a similar condition as the diagnosis or condition that is documented on the initial admission.

receipt of the claim to the provider or designee

Claims and Encounter Submission Protocols (clean claims)

Magellan Complete Care claims and encounters, including those for behavioral health services will be received and processed by our Midwest Care Management Center which is located at:

Magellan Complete Care
PO Box 2097
Maryland Heights, MO 63043

For all electronically submitted claims, Magellan will:

a. Provide electronic acknowledgement within twenty-four (24) hours from the beginning of the next business day after receipt of the claim to the electronic source submitting the claim.
b. Pay, deny or contest a claim within ten (10) business days after receipt from nursing and hospice facilities. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
c. Pay, deny or contest a claim within fifteen (15) business days after receipt from a non-nursing/non-hospice facility. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

Pay or deny the claim within ninety (90) days after receipt of non-nursing facility/non-hospice claim. Failure to pay or deny the claim within one hundred twenty (120) calendar days after receipt of the claim creates an uncontestable obligation for the Health Plan to pay the claim.

For all non-electronically submitted claims, Magellan shall:

a. Within fifteen (15) calendar days after receipt of the claim, provide acknowledgment of

or provide the provider or designee with electronic access to the status of a submitted claim.

b. Within twenty (20) calendar days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

c. Pay or deny the claim within one hundred twenty (120) calendar days after receipt of the claim. Failure to pay or deny the claim within one hundred and forty (140) calendar days after receipt of the claim creates an uncontestable obligation for the Health Plan to pay the claim.

Magellan shall reimburse providers for the delivery of authorized services as described in s.641.3155, S., including, but not limited to:

a. The provider must mail or electronically transfer (submit) the claim to Magellan within six (6) months after:
   - The date of service or discharge from an inpatient setting; or
   - The date that the provider was furnished with the correct name and address of the Health Plan.

In accordance with s.409.912,F.S., Magellan shall reimburse any hospital or physician outside the Magellan authorized geographic service area for Health Plan authorized services provided by the hospital or physician to members:

a. At a rate negotiated with the hospital or physician; or

b. The lesser of the following:
   - The usual and customary charge made to the general public by the hospital or physician; or
   - The Florida Medicaid reimbursement rate established for the hospital or physician.

Other Insurance

Medicaid is the payer of last resort. When Magellan Complete Care is the secondary or tertiary payer, the provider must submit the claim to the Health Plan within ninety (90) calendar days after the final determination of the primary payer.

a. The date of service or discharge from an inpatient setting; or,

b. The date that the provider has been furnished with the Electronic Claims Submission. Providers have the option of submitting claims electronically through Electronic Data Interchange (EDI). The advantages of electronic claims submission are as follows:
   - A secure method for transmitting claims and eligibility
   - Ability to submit multiple claims in batch mode
   - Eliminate clearinghouse costs by submitting directly to Magellan
   - Ability to send files at any time – 24 hours a day, 7 days a week

Magellan shall reimburse providers for Medicare deductibles and co-insurance payments for Medicare dually eligible members according to the lesser of the following:

a. The rate negotiated with the provider; or

b. The reimbursement amount as stipulated in s.409 .908 F.S.

Filing claims and payment

For appropriate filing information, see "CMS 1500 Claim Forms Instructions" and "UB 04 (or its successor) Claim Form Instructions." Failure to provide any of the required information can result in payment being delayed. These forms can be found on the Magellan Complete Care provider portal. If you have difficulty accessing these documents, please contact us at 1-800-327-8613.

Magellan will ensure that all claims are processed, and payment systems comply with the federal and State requirements set forth in 42 CFR 447.45,42, CFR 447.46, and Ch. 641.3155, F.S., as applicable. These guidelines are designed to compliant with the industry standards, as defined by the CPT-4, ICD-9 and the RBRVS handbooks.

Encounter Data

If a provider is paid on a capitated basis, encounter data must be submitted to the Plan according to the claim submission standards noted above.

This requirement is mandated to meet the reporting requirements of Magellan Complete Care, as well as those established by regulatory agencies and the Balanced Budget Act. Under capitation, encounter data is generally submitted in the form of a claim, and such claims are usually referred to as encounter data.

The Plan will record the encounter data received. The Plan recognizes these services as under a capitated contract and will not make payment to the provider.

The plan 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.

A capitated provider who does not submit encounter data is subject to corrective action measures and penalties under applicable state and federal law and could be terminated from the Plan.

Magellan is committed to providing the most accurate, up to date information. Please call Magellan Complete Care Provider Services at 1-800- 327-8613 for information or assistance regarding the status of any claim.

Provider Portal

Magellan Complete Care offers a secure Provider Portal to access member eligibility and PCP information. Providers can also submit and view claim status. Other options include downloading explanation of benefits (EOBs) and accessing tools such as Medicaid Disclosure Form. Magellan Complete Care encourages providers to use the portal as this is a free of charge service and accessible 24/7. To obtain username and password, please call Provider Service Line at 1-800-788-4005.

Protocols for Submitting Claims and Encounters

Magellan Complete Care continuously encourages providers to submit claims and encounters electronically. Electronic submission is less costly for the provider. Our team is trained in options for submission and is happy to schedule time with providers with questions or concerns about this method of submission. Magellan will also reach out to providers if the Agency denies encounter submissions to make the appropriate adjustments to their encounter data.

Information on submission of clean claims, claims do's and don'ts, etc. are available on the Magellan Provider Portal.

Claims and encounters can be submitted:

- Via our Direct Submit capability, allowing providers to submit claims files through a secure FTP connection or the Magellan website
- Via clearinghouse. Magellan obtains support from multiple clearinghouses in order to provide redundancy and to offer a broad range of options for our providers. Our payer ID is 01260 for Emdeon and all other clearinghouses.
- Via mail to the address below:

  Magellan Complete Care
  PO Box 2097
  Maryland Heights, MO 63043
  Claims inquiry line: 800-327-8613

Preferred Drug List

Please visit Magellan Complete Care's website for the most recent Preferred Drug List at MCCofFL.com.

Supporting Efforts to Connect with Members

Consumer advocates and accreditation bodies are asking organizations and providers to become innovators in member services and increase the use of secure technology to make accessing services more convenient for members. Magellan Complete Care supports this goal and encourages you to consider how you can use technology in these areas of service:

E-visit—email communication between providers and members after the first face-to-face visit has taken place.

E-prescribing—the physician sends a prescription directly to the member's pharmacy.

Refi l reminders—email notification to remind members to refill their medications.

E-appointment—members are able to schedule appointments electronically.

Online personal health records—members are able to keep track of their personal health information.

Healthcare Advance Directives

The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about healthcare will still be respected, the Florida legislature enacted legislation pertaining to healthcare advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law, hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning healthcare advance directives. The state rules that require this include 58A-2.0232, 59A-3 .254, 59A-4 .106, 59A-8 .0245, and 59A-12 .013, Florida Administrative Code.

Questions About Advance Directives

What is an advance directive?
It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Healthcare Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?
It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your healthcare provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a healthcare surrogate designation?
It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?
Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?
It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of healthcare workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?
No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your healthcare or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?
No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?
Florida law provides a sample of each of the following forms: a living will, a healthcare surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?
Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement, physical destruction of the advance directive, or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?
An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a healthcare surrogate and an alternate surrogate, be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your healthcare provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.

- Set up a file where you can keep a copy of your advance directive (and other important
- paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your healthcare provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your healthcare provider, attorney, or the significant persons in your life.

More Information on Advance Directives

Before making a decision about an advance directive, you might want to consider additional options
and other sources of information, including the following:

- As an alternative to a healthcare surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a healthcare surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.) You can consult an attorney for further information or read Chapter 709, Florida Statutes.
- If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.
- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest.
- The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, healthcare provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines), or call 850-245-4440.
- When you are admitted to a hospital, the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.
- If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the cremains over the Gulf of Mexico. For further information, contact the Anatomical Board of the

State of Florida at 1-800-628-2594 or www.med.ufl.edu/anatbd.

- If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at www.DonateLifeFlorida.org where you can become organ, tissue and eye donors online.
- If you have further questions about organ and tissue donation you may want to talk to your healthcare provider.

Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a healthcare surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity
www.AgingWithDignity.org
1-888-594-7437

Other resources include:

American Association of Retired Persons (AARP) www.aarp.org (Type "advance directives" in the website's search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or healthcare provider may be able to assist you with forms or further information.

Brochure: End of Life Issues
www.FloridaHealthFinder.gov 888-419-3456

Helpful Forms

Adult health assessment
Child health assessment
Grievance
Appeals
Living will
Healthcare advance directives
Designation of healthcare surrogate
Uniform donor
Florida WIC program