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2024 MEDICARE PROVIDER MANUAL

FREEDOM HEALTH

OPTIMUM HealthCare, Inc.

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1. ABOUT OUR HEALTH PLANS

Introduction

Freedom Health, Inc. and Optimum HealthCare, Inc. are wholly owned subsidiaries of Anthem, with corporate headquarters in Tampa, Florida. The company was founded with the primary goal of designing and offering outstanding healthcare products to Floridians.

Mission Statement

We are dedicated to responsibly meeting and exceeding our members' expectations by living up to our core values.

Core Values:

- We are an integrity-based company
- Every associate is committed to providing world-class service to all of our customers.
- We are respectful of our members, our providers and our associates.
- We are prudent and thoughtful managers of our financial resources.
- We care about our members and are passionate about our work.
- We are innovative developers of Medical Care Management strategies that improve the quality of our members' lives.

What makes our Health Plans different?

- We are committed to pay "clean" claims promptly and accurately, meeting all regulatory guidelines.
- Our focus is on providing the most efficient methods to obtain referrals and authorizations.
- We are committed to operating state-of-the-art information technology for claims processing, member services, enrollment management, physician profiling and data analysis.
- We have exceptionally trained physician and provider representatives available to answer all provider inquiries.

Our Service

We are adamant about our service. We will accomplish our goal of superior service to members, physicians and providers through:

- Outstanding telephone customer service.
- Cutting edge web access.
- Dedicated Provider Relations "field" staff.
- Highly trained marketing staff.
- State-of-the-art claims processing software.
- Recruiting only the most highly qualified staff
- Dedication to training.

Accreditation

Freedom Health is accredited by the National Committee for Quality Assurance (NCQA) with a designation of "Accredited". Optimum HealthCare is accredited by the National Committee for Quality Assurance (NCQA) with a designation of "Accredited". NCQA Accreditation is a rigorous and comprehensive evaluation through which the quality of our systems, processes and results are assessed, including the care that is delivered to our members.

Service Areas

In 2024, we service the following counties:

Freedom Health:

Brevard, Broward, Charlotte, Citrus, Collier, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter, and Volusia.

Optimum HealthCare:

Brevard, Broward, Charlotte, Citrus, Collier, Hernando, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter, and Volusia.

Medicare

Providing Medicare healthcare services to persons eligible in Florida is our expertise. We take pride in offering competitive benefits and excellent care.

What is Medicare? Medicare is a health insurance program for people:

- Age 65 or older.
- Age 65 or younger with certain disabilities.
- Of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has:

Part A Hospital Insurance - Most beneficiaries do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance - Most beneficiaries pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Part C Medicare Advantage – A Medicare Advantage health plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide beneficiaries with Part A and Part B benefits. Medicare Advantage health plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-for-Service health plans (PFFS), Special Needs Plans (SNP), and Medicare Medical Savings Account health plans (MSA). A Medicare Advantage health plan pays for all of the covered Medicare services for its members. Most Medicare Advantage health plans offer added benefits such as prescription drug coverage, vision, dental and hearing.

3Part D Prescription Drug Coverage - Most beneficiaries will pay a monthly premium for this coverage. Starting on January 1, 2006 new Medicare prescription drug coverage was made available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Part D Prescription

Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

2. PHYSICIAN RESPONSIBILITIES

Introduction

This section of the Provider Manual addresses the respective responsibilities of participating physicians. Our expanding network of primary care providers, as well as the growing list of specialty providers, makes it more convenient to find Freedom Health and Optimum HealthCare in your neighborhood.

The Health Plan does not prohibit or restrict participating providers from advising or advocating on behalf of a member about:

1. The member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the member to provide an opportunity to decide among all relevant treatment options.
2. The risks, benefits and consequences of treatment or non-treatment.
3. The member's right to refuse treatment and express preferences about future treatment decisions. An ancillary provider must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. A provider must ensure that individuals with disabilities are presented with effective communication on making decisions regarding treatment options.

Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations. As applicable, the Health Plan shall not prohibit the participating provider from providing inpatient services to a member in a contracted hospital if such services are determined by the participating provider to be medically necessary covered services under the Health Plan and Medicare contract.

A physician's responsibility is to provide or arrange for medically necessary covered services for members without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

A physician is further responsible to render medically necessary covered services to Health Plan members in the same manner, availability and in accordance with the same standards of the profession as offered to the physician's other patients.

Primary Care Physician (PCP) Responsibilities

The following is a summary of responsibilities specific to primary care physicians who render services to Health Plan members:

- Coordinate, monitor and supervise the delivery of health care services to each member who has selected the PCP for primary care services.
- Assure the availability of physician services to members in accordance with Section 2, Appointment Scheduling.
- Arrange for on-call and after-hours coverage.
- Submit a report of an encounter for each visit where the provider services the member, or the member receives a Health Plan Employer Data and Information Set (HEDIS) service. Encounters should be submitted on a CMS 1500 form.
- Ensure members utilize network providers. If unable to locate a participating provider for services required, contact Utilization Management for assistance.
- Allow members to participate in their health care decisions and provider input into their proposed treatment plans.
- The PCP is the "medical home" for the member and therefore directs and manages all care planning needs. This also includes implementing, coordinating and sharing the care plan with the member.
- The PCP is responsible for providing all aspects of the members' health care needs or taking responsibility for appropriately directing and arranging necessary specialized services and care with other qualified professionals.
- The Health Plan supports the care planning process during care transitions and sharing pertinent available health information developed and updated during Complex Case Management, Disease Management and Social Services case. This PCP-directed methodology enables the PCP and their support team to closely manage and monitor the member's care and health status.

Specialist Responsibilities

Specialists are responsible for communicating with the PCP in supporting the medical care of a member. Specialists are also responsible for treating Health Plan members referred to them by the PCP and communicating with the PCP for pre-certification requests. These requests must be coordinated through the member's PCP.

Responsibilities of All Health Plan Providers

The following is an overview of responsibilities for which all Health Plan providers are accountable. Please refer to your contract or contact your Provider Relations representative for clarification on any of the following:

All providers must comply with the appointment scheduling requirements as stated in the Appointment Scheduling section.

- Provide or coordinate health care services that meet generally recognized professional standards and the Health Plan guidelines in the areas of operations, clinical practice guidelines, medical quality management, customer satisfaction, and fiscal responsibility.

- Use physician extenders appropriately. Physician Assistants (PA) and Advanced Practice Registered Nurse (APRN) may provide direct member care within the scope of practice established by the rules and regulations of the State of Florida and Health Plan guidelines.

- The sponsoring physician will assume full responsibility to the extent of the law when supervising PAs and APRNs whose scope of practice should not extend beyond statutory limitations.

- APRNs and PAs should clearly identify their titles to members, as well as to other health care professionals.

- A request by a member to be seen by a physician, rather than a physician extender, must be honored at all times.

- Refer Health Plan members with problems outside of his/her normal scope of service for consultation and/or care to appropriate specialists contracted with Health Plan (PCPs only).

- Refer members to participating physicians or providers, except when they are not available, or in an emergency. Providers should contact the Utilization Management Department in the event it is medically necessary to refer a member to a non-participating provider for continuity of care purposes.

- Admit members only to participating hospitals, skilled nursing facilities (SNFs) and other inpatient care facilities, except in an emergency.

- Respond promptly to Health Plan requests for medical records in order to comply with regulatory requirements and to provide any additional information about a case in which a member has filed a grievance or appeal.

- Not bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from or have any recourse against any Health Plan member, subscriber or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a "fee-for- service" basis. Non-covered services are benefits not included by the health plan in a member's healthcare policy, are excluded by the health plan, are provided by an ineligible provider, or are otherwise not eligible to be covered services, whether or not they are medically necessary.

- Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as needed for compliance with state and federal law.

- Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.

- Maintain quality medical records and adhere to all policies governing the content of medical records as outlined in the Health Plan's quality improvement guidelines. All entries in the member record must identify the date and the provider.

- Maintain an environmentally safe office with equipment in proper working order in compliance with city, state and federal regulations concerning safety and public hygiene.

- Communicate clinical information with treating providers timely. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to the Health Plan, the member or the requesting party, at no charge, unless otherwise agreed to.

- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication regimen.

- Not to discriminate in any manner between Health Plan members and non-members.

- Fully disclose to members their treatment options and allow them to be involved in treatment planning.

- A physician/provider will allow the Health Plan to use their performance data for quality improvement activities.

Physician Licensure, Credentials and Demographic Information Changes

- Inform the Plan in writing immediately, but not to exceed five (5) business days, of any revocation, suspension, loss limitation of your DEA certification, license to practice, board certification, hospital privileges, liability insurance, or other legal credential authorizing you to practice in the State of Florida.

- Inform the Health Plan 60 days prior to making changes in tax identification number(s), telephone numbers, addresses, or any other change which would affect your status with the Plan.

Physician Availability & Accessibility

In accordance with the Physician Service Agreement, physicians agree to make necessary and appropriate arrangements to ensure the availability of services to members on a 24-hour per day, 7-day per week basis, including arrangements for coverage of members after hours or when the physician is otherwise unavailable.

In the event participating providers are temporarily unavailable to provide care or referral services to Health Plan members, they should make arrangements with another Health Plan-contracted and credentialed physician to provide these services on their behalf.

If a covering physician is not contracted and credentialed with the Health Plan, he/she must first obtain approval to treat Health Plan members. The physician should be credentialed by the Health Plan, he/she must sign an agreement accepting the participating provider's negotiated rate and agree not to balance bill Health Plan members. For additional information, please contact your Provider Relations representative.

Additionally, physicians are to establish an appropriate appointment system to accommodate the needs of Health Plan members, and shall provide timely access to appointments to comply with the following schedule:

- Urgent care within one (1) day of an illness.
- Sick care within one (1) week of an illness.

- Well care within one (1) month of an appointment request.

The physician will ensure that members with an appointment receive a professional valuation within one (1) hour of the scheduled appointment time. If a delay is unavoidable, the patient shall be informed and provided with an alternative.

Appointment Scheduling

The following criterion complies with access standards:

1. Primary Care providers should:

    - Provide medical coverage 24-hours a day, seven days a week.
    - Scheduled appointments should be seen within one (1) hour.
    - Schedule emergent referral appointments immediately.
    - Schedule routine sick care within one (1) week.
    - Schedule well care within one (1) month.

2. Specialty Care providers should:

    - Schedule well care within one (1) month.
    - Schedule routine sick care within one (1) week.
    - Schedule urgent referral within 24 hours.
    - Schedule emergent referral appointments immediately.

The Health Plan collects and performs an annual analysis of access and availability data, and measures compliance to required thresholds. The analysis can include access to:

- Well care
- Sick care
- Urgent care
- After-hours care

After Hours Services

The PCP or covering physician should be available after regular office hours to offer advice and to assess any conditions, which may require immediate care. This includes referrals to the nearest urgent care center or hospital emergency room in the event of a serious illness. To assure accessibility and availability, the PCP should provide one of the following:

- 24-hour answering service
- Answering system with an option to page the physician
- An advice nurse with access to the PCP or on-call physician

Closing Physician Panel

When closing a membership panel to new Health Plan members, providers must:

- Submit a request in writing, 60 days prior to closing the membership panel.
- Maintain an open panel to all members who were provided services prior to closing the panel.
- Submit a written notice of the re-opening of the panel, to include a specific effective date.

The Health Plan will assist physicians in providing communication to members with disabilities or language services. Please contact our Member Services Department to arrange services for the deaf, blind, or those who need a language interpreter.

PCP Initiated Member Transfer

A PCP may not seek or request to terminate their relationship with a member, transfer a member to another provider of care based upon the member's medical condition, amount or variety of care required, or the cost of covered services required by the Health Plan's member.

Reasonable efforts should always be made to establish a satisfactory provider/member relationship. The PCP should provide adequate documentation in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider/member relationship.

If a satisfactory relationship cannot be established or maintained, the PCP must continue to provide medical care for the member until such time that the member can be transitioned to another PCP.

The PCP may request that a member be assigned to another practice if his/her behavior is disruptive to the extent that his/her continued assignment to the PCP substantially impairs the PCP's ability to arrange for or provide services to either that particular member or other patients being treated by

the PCP. The PCP may request transfer of the member only after it has met the requirements of this section and only with the Health Plan's approval.

The PCP may not request transfer of a member because he/she exercises the option to make treatment decisions with which the PCP disagrees, including the option of no treatment and/or diagnostic testing. The PCP may not request transfer of a member because he/she chooses not to comply with any treatment regimen developed by the PCP or any health care professionals associated with the PCP.

Before requesting the transfer of a member, a PCP must make a serious effort to resolve the problems presented by the member. Such efforts must include providing reasonable accommodations for individuals with mental or cognitive conditions, including mental illnesses and developmental disabilities. The PCP must also inform the member of his/her right to use the Health Plan's grievance procedures.

The PCP must submit documentation of the specific case to the Health Plan for review. This includes documentation:

- Of the disruptive behavior.
- Of the PCP's serious efforts to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act.
- Clarifying that the member's behavior is not related to the use, or lack of use, of medical services.
- Describing any extenuating circumstances cited under 42CFR 422.74(d)(2)(iii) and (iv).
- Showing how the PCP provided the member with appropriate written notice of the consequences of continued disruptive behavior.
- That the PCP then provided written notice of intent to request a transfer of the member.

The PCP must submit to the Health Plan:

- The above documentation.
- A thorough explanation of the reason for the request detailing how the individual's behavior has impacted the PCP's ability to arrange for or provide services to the individual or other patients in the PCP's practice.
- Statements from providers describing their experiences with the member.
- Any information provided by the member.

A copy of the Health Plan's PCP Request for Member Transfer Form is available in the Forms section of this manual. You may also obtain a copy from our Provider Relations Department.

The request for transfer must be complete, as described above. The Health Plan will review the documentation and render a determination regarding the request for transfer. The determination will be made within forty-five (45) days of receipt of the request for transfer and will notify the PCP within three (3) days of the determination.

Except in extreme circumstances, the transfer to a new PCP will not occur until the first of the month following the Health Plan's approval. Once approved, the Health Plan will notify the member of the transfer. The PCP need not take further action.

Immediate Member Transfer Request Changes

As a provider you have the right to protect yourself and the duty to protect your staff. Violence or threatening behavior by the member is a special case and it is processed expeditiously. In the event you have a member who is violent or threatening to cause bodily harm, you are advised to contact the local authorities immediately to file a police report. You are to submit the police report to the plan and once obtained the immediate member transfer is processed.

Provider Information Changes

Prior notice to your Provider Relations representative is required for any of the following changes:

- Tax identification number.
- Group name or affiliation.
- Physical or billing address.
- Telephone or facsimile number.

Participation & Credentialing

Providers are accepted for participation after being approved by the Health Plan's credentialing process. Freedom Health, Inc. and Optimum HealthCare, Inc. do not discriminate or make credentialing decisions based on an applicant's race, creed ethnic/national identity, gender, age, or sexual orientation, or on any type of procedure or patient in which the provider specializes.

Participating physicians are required to notify the Health Plan immediately when a new provider joins their practice. Notify the local Provider Relations representative and the representative will request the CAQH number associated with the new practitioner or send an application for completion. Please see the Credentialing Overview section to learn more about our credentialing requirements.

Physician Termination

In addition to the provider termination information included in the contractual agreement with the Health Plan, the physician must adhere to the following terms:

- Any contracted physician must provide at least 60 days prior written notice before a "without cause" termination.

- Terminations occur on the last day of the month. For example, if a termination letter is dated January 15, the termination will be effective March 31.

- Physicians who receive a Not for Cause termination notice or breach the contractual agreement with the Health Plan may submit an appeal. The physician will have fifteen (15) calendar days to submit an appeal along with any additional written information in support of the appeal. If the request is not received within the fifteen (15) calendar day timeframe, the physician's right to a hearing is waived. Supporting written documentation must specifically address the termination reason noted on the termination letter. A hearing panel review will consist of at least two physicians who are peers of the physician and one Plan Administrator. The hearing panel will base its recommendation on the written information presented by the physician and Health Plan, along with any additional information requested by the panel. The appeal will occur prior to the effective date of the termination, and in most cases, within 15 business days of Health Plans' receipt of the physician's request for the appeal. A provider relations representative shall send a notification letter via certified or registered mail to the physician(s) within two weeks of receipt of the hearing panel's decision.

- The right to request an appeal is not applicable when a provider fails to maintain professional licensure or any governmental authorization required to provide services under the terms of the contractual agreement. For termination notice relating to Credentialing please refer to the Credentialing section of the manual for specific guidelines.

Please Note: The Health Plan must provide written notification to all appropriate agencies and/or members upon a physician suspension or termination, as required by regulations and statutes.

The Health Plan must provide notice to members at least 45 calendar days before the provider termination effective date for contract terminations that involve a primary care or behavioral health provider. In addition to notifying currently assigned members of the terminating primary care provider, the Health Plan would also be required to notify members who have been past patients of the terminating primary care in the past three years, even if no longer assigned to that office.

Continuity of Care – Terminated Provider

The Health Plan will provide continued services to members undergoing a course of treatment by a provider that no longer participates with the Health Plan, if the following conditions exist at the time of contract termination:

- Such care is medically necessary. Continued care is allowed through the completion of treatment, until the member selects another treating provider, or until the next Open Enrollment period – not to exceed six (6) months after the termination of the provider's contract.

- Continuation of care through the postpartum period for members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated with a terminated treating provider.

- For continued care under this subsection, the health plan and terminated provider continue to abide by the same terms and conditions as existed in the terminated contract. However, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant. This subsection does not apply to providers terminated from the Health Plan for cause.

Utilization Management & Quality Management Programs (UM/QM)

The Health Plan has UM/QM programs that include consultation with requesting providers when appropriate. Under the terms of the contract for participation with the Health Plan's network, providers agree, in addition to complying with state and federal mandated procedures, to cooperate and participate in the Health Plan's UM/QM programs, including quality of care evaluation, peer review process evaluation of medical records, provider or member grievance procedures, external audit systems, and administrative review.

Federal regulations also mandate that the Plan develop and implement quality improvement (QI) projects to ensure a culture of continuous QI. Projects may focus on one or more clinical and/or non-clinical areas with the aim of improving health outcomes and beneficiary satisfaction. Provider assistance might be requested from Plan staff in the form of supplying information from member records or encouraging member participation.

Further, to comply with all final determinations rendered pursuant to the proceedings of the UM/QM programs, all participating providers or entities delegated for Utilization Management are to use the same standards as defined in this section. Compliance is monitored on an ongoing basis and formal audits are conducted annually.

Formulary

Please refer to the Pharmacy Section of this manual for a description of the Health Plan's Formulary and prescribing criteria. Please contact your Provider Relations representative for a copy of the Formulary

Confidential Member Information & Release of Medical Records

All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally, in accordance with the HIPAA Privacy and Security Rules.

All physician practice personnel must be trained on privacy and security rules. The practice should guarantee that there is a Privacy Officer on staff, that a policy and procedure is in place to ensure confidentiality of our member's protected health information and that the practice is following procedures or obtaining appropriate authorization from members to release protected health information.

All members have a right to confidentiality. Any health care professional or person who directly or indirectly interacts with the member or handles his/her medical record must honor this right. Every practice is required to post their Notice of Privacy Practices in the office or provide a copy to members. Employees who have access to member records and other confidential information are required to sign a "Confidentiality Statement."

Confidential Information includes:

1. Any communication between a member and a physician.

2. Any communication with other clinical persons involved in the member's health, medical and mental care.

Included in this category are:

1. All clinical data, i.e., diagnosis, treatment and any identifying information such as name, address, social security number, etc.

2. Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem.

3. Any communicable disease (such as AIDS or HIV testing) protected under federal or state law.

When a member enrolls in the Health Plan, his/her signature on the "Enrollment Form" automatically, gives the healthcare provider permission to release his/her medical records to the Health Plan, other physicians in the Health Plan network who are directly involved with the member's treatment plan and agencies conducting regulatory or accreditation reviews.

Before any individual not working for the Health Plan can gain access to the member's medical record, written authorization must be obtained from the member, member's guardian or his/her legally authorized representative (except when there is a statute governing access to the record, asubpoena or a court order involved). Disclosures without authorization or consent may include, but are not limited to armed services personnel, attorneys, law enforcement officers, relatives, third party payers, and public health officials.

Adult Health Screening Services

An adult health screening is performed by a physician to assess the health status of a patient age 21 or older. It is used to detect and prevent disease, disability and other health conditions or monitor their progression. This is an all-inclusive service. The Health Plan does not allow separate billing for required or recommended components.

Screening Schedule

The Health Plan will reimburse for one adult health screening every 365 days (1 year). Adult health screenings are recommended annually for members:

Required Service Components

A physician who provides adult health screenings must be able to provide or refer and coordinate the provision of all required screening components. These components must be documented in the member's medical record.

Required Components

1. Health History - At a minimum, the following items must be documented in the member's medical record:

    - Present history
    - Past history
    - Family history
    - A list of all known risk factors, allergies and medications
    - Nutritional assessments

2. Physical Examination - At a minimum, the following items must be documented in the member's medical record:

    - Measurements of height, weight, blood pressure, and body mass index.

- Physical inspection to include assessment of general appearance, skin, eyes, ears, nose, throat, teeth, thyroid, heart, lungs, abdomen, breasts, extremities; and a pelvic, testicular, rectal and prostate exam, per gender, as appropriate.

3. Visual Acuity Testing - At a minimum, the testing must document a recipient's ability to see at 20 feet.

4. Hearing Screen - At a minimum, the screen must document a recipient's ability to hear by air conduction.

5. Required Laboratory Testing - At a minimum, the following are required and are included in the reimbursement of an adult health screening:

    - Urinalysis dipstick for blood, sugar and acetone
    - Hemoglobin or hematocrit

Manual or automated dipstick urine, hemoglobin and hematocrit tests performed during an adult health screening are not reimbursable as separate services from the adult health screening.

Recommended Service Components

6. Mammography Screening Referral - The American Cancer Society recommendations for Women at average risk for breast cancer are as follows:

    - Women between 40 and 44 should be provided the option to start screening with a mammogram every year.
    - Women 45-54 should get mammograms every year.
    - Women 55 and older can switch to a mammogram every other year, or they can choose to continue yearly mammograms. Screenings should continue as long as woman is in good health and is expected to live at least 10 more years.

    Women who are at high risk for breast cancer based on certain factors should get a breast MRI and a mammogram every year, typically starting at age 30. This includes women who:

- Have a lifetime risk of breast cancer of about 20% to 25% or greater, according to risk assessment tools that are based mainly on family history.
- Have a known BRCA1 or BRCA2 gene mutation.
- Have a first-degree relative (parent, brother, sister, or child) with a BRCA1 or BCRA2 gene mutation and have not had genetic testing themselves.
- Had a radiation therapy to the chest when they were between the ages of 10 and 30 years.
- Have Li-Fraumeni syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or have first-degree relatives with one of these syndromes.

A screening mammogram is limited to one per year. A diagnostic mammogram used to evaluate or monitor an abnormal finding may be performed more than once a year. Mammograms performed by a mobile x-ray provider are not reimbursable.

7. Colorectal Cancer Screening - According to the American Cancer Society, people who have no identified risk factors (other than age) should begin regular screening at age 45. For members with a family history or other risk factors including colorectal polyps or cancer should begin screening earlier and/or more frequently.

8. The Plan, in alignment with the American Cancer Society, recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks, and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. The discussion about screening should take place at:

    - Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years.
    - Age 45 for men at high risk for developing prostate cancer. This includes African Americans and men who have a first-degree relative (father or brother) diagnosed with prostate cancer at an early age (younger than 65).
    - Age 40 for men at even higher risk (those with more than one first-degree relative who had prostate cancer at an early age).

9. Laboratory Procedures - The following laboratory procedures are recommended, when indicated:

    - Stool for occult blood
    - Ages 40 and older, one screening mammogram every year
    - Tuberculin skin test (can be reimbursed in addition to the adult health screening)
    - Collection of cervical pap smear for sexually active females or all females 18 years old and older
    - Collection of prostatic surface antigen (PSA), if indicated for males 50 years old and older
    - Collection of specimens for sexually transmitted disease

Cultural Competency

The Health Plan has a strong commitment to diversity in its members, providers, employees and the communities it serves. Implementing a strong Cultural Competency Program (or CCP) in healthcare delivery allows the Plan to address the following goals of cultural competency:

- Provide health care services to all Plan members in a culturally competent manner.
- Help providers recognize the diverse needs of members so that they may contact the Plan to arrange appropriate assistance in order to deliver culturally competent health care and services.
- Meet cultural needs (race, ethnic background, and religion) of Plan members for all services and in all settings.
- Identify and provide linguistically appropriate services to members with limited or no English proficiency.
- Make resources available to meet members language and communication barriers.
- Respond to demographic changes in the member population.
- Eliminate disparities in the health status of members of diverse backgrounds.
- Reduce health care disparities in clinical areas.
- Improve the quality of healthcare services provided and health outcomes.
- Improve cultural competency in materials and communications.
- Demonstrate leadership in the healthcare market.

- Increase member, provider and employee satisfaction.
- Recognize value, affirm and respect the worth of the Plan's individual members, protecting and preserving their dignity.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The Plan believes that when health care services are delivered without regards for cultural differences patients are at risk for sub-optimal care. Patients may be unable or unwilling to communicate their healthcare needs in a culturally insensitive environment, reducing the effectiveness of the healthcare process. Understanding the fundamental elements of culturally and linguistically appropriate services is necessary when striving for cultural competency in healthcare delivery.

Cultural Competency is defined as a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enable them to work effectively in cross-cultural situations. Cultural competency occurs in both clinical and non-clinical areas of the Plan. In the clinical area, it is based on the patient-provider relationship. In the non-clinical arena, it involves organizational policies and interactions that impact health care services.

Evaluation of the Cultural Competency Program is performed on an annual basis as part of the Quality Management Program Evaluation. Providers may obtain a full copy of the Cultural Competency Plan, by contacting their local Provider Relations representative.

Consumer Assistance & Complaints

Please refer to the Forms section of this manual for the Health Plan's related forms.

Member Rights & Responsibilities

The Health Plan strongly endorses the rights of members as supported by state and federal laws. The Health Plan also expects members to be responsible for certain aspects of the care and treatment they are offered and receive.

All member rights and responsibilities are to be acknowledged and honored by the Health Plan staff and all contracted providers. Contracted providers will find a declaration of member rights and responsibilities in the Forms section of this manual. In addition, providers receive a handout with this information and are urged to post it in their respective offices.

Member rights and responsibilities are also listed in the Member Handbook and posted on the Health

Plan's websites at the following location:

www.freedomhealth.com
www.youroptimumhealthcare.com

-> About Us -> Utilization and Quality -> Member Rights and Responsibilities.

Advance Medical Directives

Members have the right to control decisions related to their medical care; including the decision to withhold medical or surgical means or procedures to prolong their life. The law provides that each Health Plan member (age 18 years or older of sound mind) should receive information concerning this provision and have the opportunity to sign an Advance Directive form to make their decisions known in advance. Members may also designate another person to make a decision should they become mentally or physically unable to do so.

If a member has executed advance directives, this should be noted in a prominent location in the member's medical file. Providers should request a copy of the executed advance directive to maintain in the medical record. Advance directives information, including living will and Health Care Power of Attorney forms in Spanish and English are available for Florida residents at: https://quality.healthfinder.fl.gov/report-guides

Fraud and Abuse Reporting

Under the Centers for Medicare and Medicaid Services (CMS) and Agency for Health Care Administration (AHCA) guidelines, the Health Plan is required to have an effective fraud, waste and abuse (FWA) program in place. The Health Plan has implemented a FWA program to prevent, detect and report health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. The Health Plan will use a number of processes and procedures to identify and prevent fraud and abuse. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, civil and/or criminal prosecution, fines and other penalties.

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-866-7226 or 850-414-3990). The reward may not exceed the lesser of 25 percent of the amount recovered or $500,000 in a single case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

CMS requires that Medicare Advantage Organizations and Medicare Prescription Drug Plans apply certain training and communication requirements to all entities they partner with to provide benefits or services to individuals enrolled in Medicare Advantage and/or Medicare Part D plans. To meet such requirements, this section covers general compliance training, as well as Fraud, Waste and Abuse Training guidelines. The guidelines in this document are governed by the requirements outlined in the Medicare Managed Care Manual Chapter 21 and the Prescription Drug Benefit Manual Chapter 9.

Provider Requirements

- All providers and their employees must complete training within 90 days of hiring and annually.
- Providers should maintain records of all training – including dates, methods of training, materials used for training, identification of trained employees via sign-in sheets or other method, for a period of no less than 10 years.
- The Plan may request such records to verify that training occurred.
- If the organization has contracted with other entities to provide health and/or administrative services on behalf of our Plan members, you must provide the training material to your subcontractor for training and ensure the subcontractor and any other entity they may have contracted with to provide services, also maintains records of the completed training.
- All contracted entities should have policies and procedures to address Fraud, Waste and Abuse – including effective training, reporting mechanisms and methods to respond to detected offenses.

Fraud – is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representation, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.

Some examples of fraud:

- Billing for services not furnished.
- Soliciting, offering or receiving a kickback, bribe or rebate.
- Violations of the Physician Self-Referral (“Stark”) prohibition.
- Member being solicited by marketing companies, pharmacies and telemedicine doctors for

the purpose of obtaining Protected Health Information and convincing the member to agree to allow a pharmacy to supply, compounds, topical creams, diabetic testing equipment and various braces such as knee or back braces.

- Physicians/Pharmacies cannot bill for both Part B and D for the same product or service.

Waste - Generally, means over-use of services, or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources.

Abuse –describes practices that may directly or indirectly result in unnecessary costs to the Medicare Program. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care..
Some examples of abuse:

- Billing for unnecessary medical services
- Charging excessively for services or supplies.
- Misusing codes on a claim, such as upcoding or unbundling codes. Upcoding is when a provider assigns an inaccurate billing code to a medical or treatment to increase reimbursement.

Pertinent Statues, Laws and Regulations

False Claims Act

The Federal False Claims Act 1985 permits a person with knowledge of fraud against the United States Government, referred to as the "qui tam plaintiff," to file a lawsuit on behalf of the government against the person or business that committed the fraud (the defendant). If the action is successful, the qui tam plaintiff is rewarded with a percentage of the recovery.

Violations of Medicare laws and the Medicare Fraud and Abuse Statute also constitute violations of the False Claims Act. Since the Federal Government indirectly funds Medicaid, violations of Medicaid laws will also be covered under the False Claims Act.

The Federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have also enacted false claims laws modeled after the Federal False Claims Act.

A “claim” is broadly defined to include any submissions that results, or could result, in payment. Claims “submitted to the government” includes claims submitted to intermediaries such as state

agencies, managed care organizations, and other subcontractors under contract with the government to administer healthcare benefits.

Liability can also be created by the improper retention of an overpayment. Examples include:

- A physician who submits a bill for medical services not provided.

- A government contractor who submits records that he/she knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

- An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare health plan sponsor.

Whistleblower and Whistleblower Protections

The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.

Individuals who file such suits are known as 'whistleblowers'. The federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.

Anti-Kickback Statute

The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under federal health care programs.

The Anti-Kickback law is intended to ensure that referrals for healthcare services are based on medical need and not based on financial or other types of incentives to individuals or groups.

Examples include:

- A frequent flier campaign in which a physician may be given a credit toward airline frequent flier mileage for each questionnaire completed for a new patient place on a drug company's product.

- Free laboratory testing offered to health care providers, their families and their employees to induce referrals.

In addition to criminal penalties, violation of the Federal Anti-Kickback Statute could result in civil monetary penalties and exclusion from federal health care programs, including Medicare and Medicaid programs.

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI).

HIPAA Privacy - The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.

HIPAA Security - The Security Rule outlines specific protections and safeguards for electronic PHI.

If you become aware of a potential breach of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.

Potential FWA committed by: Pharmaceutical Manufacturer

- Illegal Off-label Promotion - Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotion campaigns.
- Illegal Usage of Free Samples - Providing free samples to physicians/pharmacies knowing and expecting those physicians/pharmacies to bill the federal health care programs for the sample.
- Billing for items or services not rendered or not provided as claimed.
- Submitting claims for equipment or supplies and services that are not reasonable and necessary.
- Double billing resulting in duplicate payment.
- Billing for non-covered services as if covered.
- Knowing misuse of provider identification numbers, which results in improper billing.
- Unbundling (billing for each component of the service instead of billing or using all-inclusive code).
- Failure to properly code using coding modifiers.
- Altering medical records.

- Improper telemarketing practices.
- Compensation programs that offer incentives for items or services ordered and revenue generated.
- Inappropriate use of place of service codes.
- Routine waivers of deductibles/ coinsurance.
- Clustering.
- Up coding the level of service provided.

Potential FWA committed by: Skilled Nursing Facility ("SNF")

- SNFs improperly up-coding resident RUGs assignments to gain higher reimbursement.
- SNF improperly utilizing therapy services to inflate the severity of the RUG classification to obtain additional reimbursement.
- DME or supplies offered by DME provider that are covered by the Medicare Part A benefit in the SNF's payment.

Potential FWA committed by: Hospital

- Failure to follow the same day rule.
- Abuse of partial hospitalization payments.
- Same day discharges and readmissions.
- Improper billing for observation services.
- Improper reporting of pass through costs.
- Billing on an outpatient basis for "inpatient only" procedures.
- Submitting claims for medically unnecessary services by failing to follow local policies.
- Improper claims for cardiac rehabilitation services.

Potential FWA committed by: Physician and Others

- Chiropractor intentionally billing Medicare for physical therapy and chiropractic treatments that were never actually rendered for the purpose of fraudulently obtaining Medicare

payments.

- A psychiatrist billing Medicare, Medicaid, the Health Plan and private insurers for psychiatric services that were provided by the practices' nurses rather than her or himself.
- Physician certifies on a claim form that he performed laser surgery on a Medicare beneficiary when he knew that the surgery was not actually performed on the patient.
- Physician instructs his employees to tell the OIG investigators that the physician personally performs all treatments when, in fact, medical technicians do the majority of the treatment and the physician is rarely present in the office.
- Physician, who is under investigation by the FBI and the Health Plan, alters records in an attempt to cover up improprieties.
- Neurologist knowingly submits electronic claims to the Medicare carrier for tests that were not reasonable and necessary and intentionally up-coded office visits and electromyograms to Medicare.
- Podiatrist knowingly submits claims to the Medicare and Medicaid programs for non-routine surgical procedures when he actually performed routine, non-covered services such as the cutting and trimming of toenails and the removal of corns and calluses.
- Performing tests on a beneficiary to establish medical necessity.

Potential FWA committed by:

Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS)

- DME provider billed for items or services not provided to the beneficiary.
- Continued billing for rental items after they are no longer medically necessary.
- Resubmission of denied claims with different information in an attempt to be improperly reimbursed.
- Providing and/or billing for substantially excessive amounts of DME items or supplies.
- Upcoding a DME item by selecting a code that is not the most appropriate.
- Providing a wheelchair and billing for the individual parts (unbundling).
- Delivering or billing for certain items or supplies prior to receiving a physician's order and/or appropriate certificate of necessity.
- Completing portions of the certificate of necessity that is reserved for completion by the

treating physician only.

- Cover letters to encourage physicians to order medically unnecessary items or services.
- Improper use of KX modifier.
- Providing false information on the DMEPOS supplier enrollment form.
- Knowing misuse of a supplier number, this results in improper billing.
- Furnishing more visits than as medically necessary.
- Duplicate billing for the same service.
- Submission of claims for home health aide services to beneficiaries that did not require any skilled qualifying service.
- Provision of personal care services by aides in assisted living facilities when such is required by the assisted living's state licensure.
- Providing services at no charge to an assisted living center.

Health Plan's Processes for Identification of Fraud, Waste and Abuse

The Health Plan has software and monitoring programs designed to identify indicators for fraud, waste and abuse, including, but not limited to:

- Multiple billing: Several payers billed for the same services (e.g. billing medications under Part A or Part B and then billing again under Part D.
- Billing for non-covered services.
- Duplicate billing.
- Unbundling of charges.
- Up-coding.
- Fictitious providers.
- Billing of unauthorized services.
- Billing with the wrong place of service in order to receive a higher level of reimbursement.
- Claims data mining to identify outliers in billing.
- Billing for services or supplies not provided.
- Improper use of KX modifier.
- Failure to follow the same day rule (hospital).
- Abuse of partial hospitalization payments.

- Billing on an outpatient basis for "inpatient only" procedures.

Reporting Obligation and Mechanisms

If you identify or are made aware of potential misconduct or a suspected fraud, waste, or abuse situation, it is your obligation to report it. To report suspected fraud, waste, or abuse, you can contact the Health Plan in one of these ways:

- Compliance Hotline: (888) 548-0094 (Managed by Navex/Ethics Point)
- Toll-Free Fax: (888) 548-0092; Local-Fax: (813) 506-6176
- E-mail: compliancereporting@americas1stchoice.com.
- Mailing Address: PO Box 152137, Tampa, FL 33684
- Ethics Point Web Portal: *https://www.americas1stchoice.ethicspoint.com* (You will be redirected to this site.)

To report Compliance, HIPAA, and Fraud, Waste and Abuse issues you may also contact:

- Florida State Attorney General: 1-866-966-7226
- Agency for Health Care Administration, Medicaid Program Integrity: 1-888-419-3456
- Department of Financial Services, Division of Insurance Fraud: 1-800-378-0445
- Office of Inspector General at https://oig.hhs.gov.
- Department for Health and Human Services (DHHS): www.hhs.gov/ocr/hipaa.
- Centers for Medicare and Medicaid Services: www.cms.gov.

DSNP Reporting

To report any health care facility or provider that may have violated the law while providing services to dual eligible members, providers are encouraged to contact AHCA's Complaint hotline at 1-888-419-3456 or by completing the online complaint form found at https://apps.ahca.myflorida.com/hcfc/ or if there are any areas of concern relative to the operation of any entity providing DSNP services, providers can submit an online complaint form found at https://www.flmedicaidmanagedcare.com/complaint#%2F or by contacting AHCA's Complaint hotline at 1-877-254-1055.

The Compliance Reporting program has been established in effort to enhance communication and empower us to promote safety, security, and ethical behavior. This service is available 24 hours a day and provides multiple channels for providers to communicate their concerns confidentially and anonymously.

Callers are encouraged to provide contact information should additional information be needed. Retaliation and/or intimidation for good faith reporting is strictly prohibited. The Health Plan will notify the CMS Regional office of any issues that involve Medicare members.

Resources

Medicare Advantage and Cost Plan Compliance Program Guidelines

http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

Office of the Inspector General

https://oig.hhs.gov/fraud/

Provider Compliance Resources

https://www.cms.gov/Outreach-and-Education/Outreach-and-Education

Compliance Requirements

The Health Plan has implemented a Compliance Program to promote the prevention, detection, and resolution of instances of conduct that do not conform to Federal and State Health Care Program requirements. The Plan will take immediate steps to correct any violations, including but not limited to imposing appropriate disciplinary actions monitoring, administrative sanctions, suspension or termination as an authorized provider, loss of licensure, civil and/or criminal prosecution, fines and other penalties.

The Compliance Program Requirements apply to all First Tier Down Stream and Related Entities (FDRs) including health care providers contracted by the Health Plan to provide administrative services or health care services to a Medicare eligible individual under the Medicaid, Medicare Advantage Program or Part D program. The guidelines in this document are governed by the Medicare Managed Care Manual Chapter 21 and the Prescription Drug Benefit Manual Chapter 9.

First Tier Entity - Any party that enters into a written agreement with a Plan sponsor to provide administrative or health care services for a Medicare eligible individual under the Medicare Advantage program.

- Examples include, but are not limited to, pharmacy benefit manager (PBM), contracted hospitals or providers.

Downstream Entity - Any party that enters into a written agreement below the level of the arrangement between a sponsor and a first-tier entity for the provision of administrative or health care services for a Medicare eligible individual. These arrangements continue down to the level of the ultimate provider of both health and administrative services.

Examples include, but are not limited to, pharmacies, claims processing firms, billing agencies.

Related Entity - Any entity that is related to the sponsor by common ownership or control and,

1. performs some of the sponsor's management of functions under contract or delegation;
2. furnishes services to Medicare enrollees under an oral or written agreement; or
3. lease real property or sells materials to the sponsor at a cost of more than $2,500 during a contract period.

Compliance Program Requirements

- You must distribute our Standards of Conduct and/or Compliance Policies & Procedures (or your own comparable document) to your employees and/or downstream entities within 90 days of hire or contracting, when there are material changes or updates, and at least annually thereafter.

- General Compliance and Fraud, Waste and Abuse (FWA) training and education must be completed within 90 days of contracting or hiring and at least annually thereafter. All providers and their employees must complete the required training, maintain evidence of completed training including certificates of completion, for a period of 10 years and provide evidence of completion upon request.

- General Compliance and Fraud, Waste and Abuse training and education must be comparable to the elements set forth in company's Standards of Conduct and/or Policies & Procedures. You are responsible for developing FWA training content or utilizing another organization's FWA training content.

- You can also locate Combating Medicare Parts C and D Fraud, Waste and Abuse Training module at https://www.cms.gov/training-education/medicare-learning-network/web-based-training and additional Compliance Training Resources at https://oig.hhs.gov/compliance/provider-compliance-training/.

- Screening of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the General Services Administration (GSA) System for Award Management (SAM) Exclusion Databases is required prior to hire and/or contracting and monthly thereafter. You must promptly remove any individual or entity appearing on either of these lists from any work related to the Plan's Medicare contract.

- Widely publicize and distribute information regarding the reporting mechanisms available including anonymous avenues for all employees and Downstream Related Entities to report instances of non-compliance and/or suspected or detected FWA. You may utilize the Plan's reporting mechanisms or train your employees and Downstream Related Entities on your internal reporting process. Reports of compliance concerns, violations to the Medicare Program and/or suspected FWA that affect our Plan must be reported to us immediately.

Report concerns impacting the Plan as they are identified utilizing the following mechanisms:

- Compliance Hotline: (888) 548-0094 (Managed by Navex/Ethics Point)
- Toll-Free Fax: (888) 548-0092; Local-Fax: (813) 506-6176
- E-mail: compliancereporting@americas1stchoice.com
- Ethics Point Web Portal: *www.americas1stchoice.ethicspoint.com* (You will be redirected to this site.)

Marketing Prohibitions

Providers shall comply with all Medicare Marketing Guidelines as set forth by the Centers for Medicare and Medicaid Services (CMS). At minimum, participating physicians and providers should observe the following:

1. Providers or provider groups are prohibited from distributing printed information comparing benefits of different health plans, unless the materials have consent from all of the health plans listed, and received prior approval from the Centers for Medicare and Medicaid Services (CMS);

2. Providers shall not accept enrollment applications or offer inducement to persuade beneficiaries to join plans;

3. Providers may not offer anything of value to induce plan enrollees to select them as a provider; and

4. Provider offices or other places where healthcare is delivered shall not accept applications for health plans, except in the case where such activities are conducted in common areas in the health care setting.

3. CREDENTIALING

Introduction

Review and approval through the Health Plan's credentialing process is required for network provider participation. During this process, the credentialing application is reviewed against the Health Plan's policies and procedures and the provider's credentials are verified. The Credentialing Committee, which is the Peer Review Committee of the Health Plan, reviews any issues such as malpractice claims history, licensure sanction or Medicare sanctions. It is the provider's responsibility to fully complete the entire credentialing application and supply a written explanation to any item of negative information.

Acceptable credentialing applications include the Health Plan's own applications as well as the Council for Affordable Quality Healthcare (CAQH) application. The CAQH application must have a current attestation and be updated with all supporting documents. An application cannot be processed until all areas are completed and all documents are provided.
Please note that practitioners have the following rights in connection with the credentialing process:

The right to review information submitted to support their credentialing application:

- Upon request to Credentialing, a practitioner has the right to review information that is obtained by the Health Plan from outside sources and which it uses to evaluate the credentialing application. The exception to the information that may be reviewed is peer references and information that is peer review protected.

The right to correct erroneous information:

- When information is obtained by the Health Plan from other sources, and the information substantially varies from that supplied by the practitioner, in accordance with Credentialing Policy CR 1, the Health Plan will:

1. Notify the practitioner of the right to correct the erroneous information.
2. Provide the timeframe for making the changes.
3. The format for submitting the changes.
4. The name of the person to whom, and the location where the corrected information must be sent.
5. The right to receive the status of their credentialing or re-credentialing application upon request.

- The Health Plan will respond to a practitioner's request for credentialing application status within 15 business days. The information provided will advise of any items still needed, or any difficulty or non-response in obtaining a verification response.

The application is then taken through the initial credentialing process and brought to the Credentialing Committee, (composed of practicing practitioners credentialed by the Health Plan). Any request by the Credentialing Committee for additional information will be immediately forwarded to the practitioner.

Practitioners are initially credentialed for a 36-month credentialing period and are required to be re-credentialed prior to the end of the 36-month timeframe. The Health Plan may request updates for expired documentation such as malpractice insurance. If there are changes to any of the information/documentation submitted in support of the application such as board certification status, or admitting hospital privileges, please let the Health Plan know.

Credentialed Practitioners, Facilities and Suppliers

The following licensed practitioner types are required to be credentialed in order to provide medical services to Health Plan members:

- Medical Doctors (MDs)
- Osteopathic Doctors (DOs)
- Podiatric Doctors (DPMs)
- Chiropractic Doctors (DCs)
- Optometric Doctors (ODs)
- Oral Surgeons (DMD's or DDSs)
- Psychologists (Psych-Ds)
- Advanced Practice Registered Nurse (APRNs)

- Physician Assistants (PACs)
- Certified Nurse Midwifes (CNMs)
- Licensed Midwives
- Audiologists
- Physical Therapists (PTs) - if contracting directly with us. If through an accredited facility, then only the facility needs to be credentialed
- Occupational Therapists - Same as PTs
- Speech Therapists - Same as PTs
- Licensed Clinical Social Workers (LCSWs)
- Masters in Social Work (MSWs)
- Licensed Mental Health Counselors (LMHCs)
- Licensed Marriage & Family Therapists (LMFTs)

The Health Plan also credentials facilities and suppliers. A completed Application/Data Collection Form and the following supporting documents are required but are not limited to CMS Certificate; General/Commercial Insurance Certificate and Accreditation Certificate or Survey Report as applicable.

These facilities and supplier providers are:

- Hospitals
- Ambulatory Surgery Centers (ASC)
- Skilled Nursing Facilities (SNF)
- Diagnostic Facilities
- Inpatient Hospice Facilities
- Dialysis Centers
- Home Health Agencies
- Nursing Homes
- Durable Medical Equipment (DME) providers
- Comprehensive Outpatient Rehabilitation Facilities
- Outpatient Physical, Occupational & Speech Therapy (PT, OT, ST) Facilities

The complete credentialing process must be approved prior to the delivery of health care services to members.

NOTE: Hospital-based practitioners are not required to be credentialed or re-credentialed by the Health Plan.

Initial Credentialing Process

The initial credentialing process is as follows:

The physician/provider/supplier fully completes all necessary sections of the credentialing application/form and submits the required documents to the Health Plan. A CAQH application is acceptable if all the information and documents are current. Once providers sign a Medicare contract, the Health Plan will verify the provider's name does not appear on the listing of Medicare Opted-Out Providers, OIG Exclusion List, EPLS List, or the CMS Preclusion List.

Primary source verification is performed concerning education, training, board certification, licenses and other submitted documents and information The Credentialing team may ask for additional explanations if deemed necessary prior to the application being presented to the Credentialing Committee. The provider's file is then presented to the Credentialing Committee.

If approved, the file is noted accordingly. If the committee requests additional information, the request is conveyed to the provider, and the file is placed in a pending status, awaiting the requested information. Once received, the Committee will re-evaluate the application.

Upon approval, the provider information is submitted for loading into the Health Plan's database for purposes of claims payment and directory listing as applicable. The physician/provider/supplier is notified in writing of their credentialed status within 60 calendar days of the committee's decision.

The credentialing process may take approximately 90 days from receipt of complete application through presentation to the Credentialing Committee.

Re-Credentialing

Credentialed physicians/providers/suppliers must be re-credentialed every 36 months. The Credentialing Department establishes this date as 36 months following the provider's approval. The provider will be notified approximately 120 days prior to the scheduled re-credentialing date. The re-credentialing review process is similar in structure to the initial credentialing process and includes the following:

- Completion of a re-credentialing application or CAQH application;
- Verification is performed concerning licenses, board certifications and other submitted

documents and information;

- Internal Health Plan information regarding complaints, grievances and quality management, as applicable.

If a physician fails to return the re-credentialing application in a timely fashion and their credentialing period lapses, the physician may not render services to a Health Plan member until the initial credentialing process is completed.

Liability Insurance

The Health Plan's credentialing policies concerning liability coverage conform to Florida Statutes. In the absence of evidence of professional liability insurance, physicians will be asked for their State Financial Responsibility form as part of their credentialing packet. This will allow the Health Plan to confirm compliance with these guidelines.

Upon request, a provider must provide the health plan with evidence of liability coverage and any renewals, replacements, or changes.

Updated Documents

The Health Plan is required to maintain documentation/verification of certain documents that expire throughout the practitioner's participation with the Health Plan. These documents include but are not limited to medical license and board certification.

Ongoing Monitoring

After a practitioner is approved for participation in the Health Plan, ongoing monitoring of the provider's credentials is performed in accordance with State, Federal, and NCQA accreditation requirements.

Ongoing monitoring involves monthly/quarterly review of the following:

- Licensure sanctions
- CMS Preclusion List
- Medicare OIG sanctions listing
- The Excluded Parties Listing System Sanctions (EPLS) via SAM.gov
- Medicare opt-out
- Report of practitioners who exceed the complaint volume thresholds

In the event a provider is identified as being excluded from participation in any government program

or is excluded via the EPLS, or has opted-out of Medicare, such provider is automatically ineligible to participate with the Health Plan and is notified accordingly.

Practitioners identified with a state licensure sanction that does not remove licensure are requested to provide full information to the Health Plan and the information is then reviewed by the Medical Director and/or the Credentialing Committee for acceptance.

When the practitioner is identified as meeting or exceeding the member complaint volume threshold set by the Health Plan, the practitioner is notified via letter, with a follow-up office visit from the Provider Relations Representative. In the event member complaints exceed the Health Plan's threshold specific to office site quality, a satisfactory site inspection evaluation is required, and the evaluation is performed by the Provider Relations Department

Physician Appeal Rights – Non-Approval of Credentialing

In the rare event that the committee denies a physician's credentialing application; the physician has the right to appeal the decision within 30 days of receiving the denial notice. The appeal rights are provided and the notification letter will specify the reason(s) for the non-approval. Appeals for non-approvals are held via teleconference.

Physician Appeal Rights – Adverse Participation Decision

In the event the Health Plan makes an adverse participation decision against a participating physician, the affected physician, will be notified in writing within 30-days of the adverse decision and be provided notice of rights to appeal. The letter will specify the reason for the adverse determination and will include, if relevant, the data used to evaluate the physician. The letter will include:

- Notification of a 30-day timeframe from the physician's receipt of the Health Plan's letter to submit an appeal to the Health Plan;
- The name of the person to whom the appeal should be submitted;
- The physician's right to submit any additional information in support of the appeal.

If an appeal is requested, the committee will be notified, and any additional information submitted by the practitioner will be reviewed as expeditiously as possible. Practitioners that receive a final termination decision for a validated quality of care issue will be reported to the State Licensure Board and the National Practitioner Data Bank in accordance with State and Federal requirements.

4. MEMBER ELIGIBILITY & SERVICES

Member Services

The primary purpose of the Health Plan's Member Services Department is to answer questions and attempt to resolve issues, problems, and concerns raised by members.

Beginning April 1st through September 30th, our office is open Monday through Friday from 8:00 a.m. until 8:00 p.m. EST. From October 1st through March 31st , the office is open seven days a week, from 8:00 a.m. until 8:00 p.m.

The Member Services Department can be reached at 1-800-401-2740 for Freedom Health and 1-866-245-5360 for Optimum HealthCare. Members with hearing and/or speech impairments should call our toll-free TTY line at 711. We also encourage the use of our website at www.freedomhealth.com and www.youroptimumhealthcare.com
Members and physicians may contact Member Services to:

- Change a primary care physician
- Receive educational materials
- Learn about referrals and authorizations
- Disenroll from the Health Plan
- Obtain a new identification card
- Find participating pharmacies
- Verify member eligibility
- Ask co-payment, co-insurance and deductible questions
- Inquire about claims payment
- Learn more regarding member benefits for all lines of business
- File a member complaint/grievance
- Notify the Health Plan of a change in information – new address, phone number, or other personal information
- Receive member assistance with the Appeals & Grievance process

Staff Selection and Training

The Member Services Department is committed to hiring highly qualified individuals, providing top- notch training and monitoring activities to support attainment of Health Plan's service commitments. Telephone calls are monitored to maintain standards regarding information accuracy,

timely follow-up and member service attitudes.

Service Standards

The Member Services Department is designed to address issues, solve problems, answer questions and listen to concerns from members and physicians or providers. Our service commitments are to:

1. Answer calls within 30 seconds.
2. Respond to voice mail messages within 24 business hours.

The Health Plan will track the types of issues that you and your staff bring to our attention so that we may correct any underlying problems. The Health Plan also maintains written case management and continuity of care protocols that include appropriate referral and scheduling assistance of members who need specialty health care/transportation services.

Member Identification Card

Each member will receive an identification card that allows them access to receive services from the Health Plan's network of participating physicians/providers. A sample of an identification card for each product is available in the Forms section of this manual. Physicians/providers should ask to see the member identification card at each scheduled appointment.

Some important points to remember:

- The practice should make a copy of both sides of the identification card for their member medical record.
- For purposes of privacy, the identification card has a unique member number used for most transactions.
- The identification card lists the most common co-payments, co-insurance and deductible amounts.
- The identification card lists the toll-free Member Services telephone number.
- The identification card has the address to mail claims.
- The identification card does not reflect the effective date of the provider. The date listed is the date that member became effective with the Health Plan.
- The physician/provider can verify eligibility by requesting to see the member identification card each time that the member has an appointment. The member should also be asked if there have been any changes since their previous appointment.

Member Transfers

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

- The member's decision to transfer should be strictly voluntary.
- The member must not have been directly recruited by phone or in person by anyone involved with the primary care office.
- The member must not have been influenced to transfer to or out of the office due to improper and/or incorrect information or for medical reasons.
- Upon the member's request and completion of a Medical Record Release Form, the office is required to send his/her medical records to the newly selected primary care office.

Methods of Eligibility Verification

Providers will have up to four (4) methods to verify member eligibility:

1. Member Services – Member Services Department staff is available to verify member eligibility toll free at 1-800-401-2740, from April 1st through September 30th, Monday through Friday from 8:00 a.m. until 8:00 p.m. EST and from October 1st through March 31st, seven days a week, from 8:00 a.m. until 8:00 p.m. EST.

2. Monthly Roster – The PCP will receive a "Monthly Roster" of members who are assigned to their practice for each line-of-business with which they have agreed to participate. However, the Health Plan cannot guarantee that a member who appears on the Monthly Roster will not be "retroactively" terminated due to failure to pay their premium or termination (Medicare).

3. Application Form – For new members who have not yet received their identification card with the new member packet, a copy of their application form will suffice as a form of eligibility verification. We do encourage that network physicians/providers use a second form of verification under these circumstances for "non-urgent" medical services. This is only applicable to Medicare members.

4. Provider Portal – The Health Plan has a web portal to verify member eligibility, benefits and claims status quickly and efficiently. You can go to www.freedomhealth.com or www.youroptimumhealthcare.com to register/log on to the Provider Portal.

Please be aware that the confirmation e-mail containing the log on ID could be in your spam folder. Online member information is available to physicians/ providers in "real-time" and will meet current Federal privacy guidelines. We encourage physicians to verify member eligibility prior to the appointment and ensure that the member is eligible for covered benefits with the Health Plan. Eligibility can be gained or lost within a month's time.

For questions regarding the web portal, please refer to your provider Portal User Manual. A copy is available for download on the registration page of the website, or you may contact your Provider Relations representative to have the document sent to you.

5. CARE MANAGEMENT DEPARTMENT

Introduction

The Health Plan's Utilization Management (UM) and Case and Disease Management Departments are involved in the coordination of care for our members. The roles of the Department include utilization review of pre-service requests, concurrent review of members in hospitals and skilled nursing facilities, disease management (especially for members with high-risk diseases such as diabetes and cardiovascular disease) and complex case management (for members with high-risk issues, non-compliance or multiple acute disease processes).

The UM Department is available to assist your office regarding any questions related to the pre-certification process. UM and Case and Disease Management work closely with providers and members to help coordinate care and enhance member understanding and adherence to their treatment plan. This includes gathering clinical information from provider offices and providing communications relative to members' involvement in case management activities. Additionally, members are able to self-enroll in a Diabetes and/or Cardiovascular Disease Management program by completing an enrollment form on the Member Portal. Please encourage your members to register on the Member Portal by visiting www.freedomhealth.com or www.youroptimumhealthcare.com. Once they register, members will have access to many helpful features such as:

- Interactive Self-Management Tools
- Personal Health Tracker
- Health and Wellness Education
- Ability to place orders for OTC items and diabetic supplies
- Complete their Health Assessment Form
- Get electronic refill reminders for their prescriptions

All hospitalized members receive a call following discharge from the Health Plan's Case and Disease Management Department to ensure that they have all post-discharge needs met such as equipment, and/or nursing assistance, as appropriate. The Health Plan encourages members to see their PCP within 7 days of discharge from an inpatient stay. This includes members who were admitted for an alcohol and/or other substance abuse related event. In the previous year, a very small percentage of our Medicare members have received timely follow up care after an alcohol and/or other substance abuse related event.

During the post-discharge call, the Health Plan's Case and Disease Management staff may identify barriers or care gaps that may keep members from receiving necessary services or follow-up care. In such instances, the member will receive assistance from a Health Plan nurse case manager and/or Social Worker. The staff will communicate with the member's provider(s) to facilitate coordination of care with the goal of self-management to ultimately avoid a preventable readmission to an inpatient setting.

Care Management Philosophy

The Health Plan's goal is to create partnerships with physicians, providers and members that result in the following:

1. Avoidance of acute illnesses and diseases through prevention and/or early detection of medical problems.

2. Enhancement and improvement of general levels of health and fitness.

3. Enabling of members through education, to develop awareness of the importance of prevention and health maintenance as key ingredients to general health and fitness.

4. Assistance for members in understanding their partnership role with health providers.

The Department will strive to achieve these objectives through three methods:

1. Developing an efficient utilization management program as outlined below.

2. Developing strong disease management and lifestyle management programs.

3. Establishing effective case management programs that are focused on care coordination for potential or existing catastrophic or acute medical situations.

UM Staff Availability

The Utilization Management (UM) Department is available for all pre-certification requests from 8:00 a.m. to 5:00 p.m. Monday through Friday (excluding holidays). After routine business hours, UM can be reached by calling the Department's regular telephone number to arrange for discharge planning or emergent needs. This number will connect to the on-call clinical staff that will be able to assist with any UM function. Staff identifies themselves by name, title and organization when initiating or returning calls.

Contact Information

The Health Plan's Utilization Management (UM) Department may be reached at:

Telephone: 1-888-796-0947
Fax: 1-866-608-9860 or 1-888-202-1940

General Information

The Medicare Utilization Management Program practices the "Medical Home Office" model in a majority of its counties. Enrolled members must seek a referral from the Primary Care Physician (PCP) before receiving services from a specialist or other medical provider. Once the initial referral is generated, the specialist must coordinate all services through the PCP (except in selected counties). The PCP is responsible for submitting all pre-certification requests (see Pre-Certifications) to the Health Plan, except for the excluded counties.

The timeframes for responses to requests are as follows:

Standard Requests

The Department processes authorization requests as quickly as possible. Many of our requests are completed on the same day received, and our average turnaround time for all requests for service is less than 2 days, if all information is complete and applicable supporting documentation provided. Please submit requests through the provider portal for the quickest response. Alternatively, requests can be faxed to (866) 608-9860 or (888) 202-1940.

Expedited/STAT Requests

Expedited requests are defined by Medicare as a request where "applying the standard time for making a determination could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function." These requests must be completed, including a notification to the member, within 72 hours from the time received at the Health Plan. In order for our pre-

certification staff to continue to process all requests for service quickly, we ask that you please review all requests that your office submits before you write STAT, URGENT, ASAP, or EXPEDITED. You can obtain an expedited determination for all services that meet the above definition in one of two ways:

- Use the Pre-Certification Form. There is a section for the physician to confirm that the request meets the definition of expedited. The confirmation will be the physician's signature and a brief note indicating his/her reason why the requested service meets, the above expedited definition. Expedited requests may be submitted by provider portal or by fax to (866) 608-9860 or (888) 202-1940.

- Call the Health Plan at any time to discuss a case or request and expedited determination at 1-888-796-0947 or request an expedited determination.

Status of a Pre-Service Request

A provider may determine the status of an authorization in two ways:

1. Call the UM Department during normal business hours, 8:00 a.m. to 5:00 p.m. on weekdays, to check the status of a request; or

2. Access the Health Plan's Provider Portal, where you can review the status of a member's authorization request. If you have questions regarding the Provider Portal or would like access, please contact your Provider Relations representative for assistance.

A member should contact Member Services to receive information regarding a requested service.

Referrals

The Referral Process is the process a PCP performs when requesting services for a member from another provider that do not require pre-certification by the Health Plan.

The Referral Process is determined by the PCP location. For information regarding the Referral Process for your office, please contact your Provider Relations representative.

Pre-Certifications

Pre-certification is the process of requesting and obtaining authorization prior to elective inpatient admissions or selected ambulatory procedures and services. While coverage determination is based on Health Plan documents and nationally recognized guidelines, clinical information regarding the service is necessary to determine whether clinical guidelines for coverage are met. Failure to obtain pre-certification for services that require it will result in denying provider claims for no

authorization.
The process to obtain a pre-certification for services and supplies process may vary by office location or conditions in your provider agreement. For details on how the pre-certification process is handled for your office, please contact your Provider Relations representative.

Member Request to Health Plan for Decision on Services

Medicare mandates that all members have the right to contact the Health Plan directly to request a decision on a service they believe the Health Plan (or Medicare) should provide or pay for. This request is considered a request for an organization determination, and the Health Plan must review and respond to this request as it would from any provider.

Member requesting specialist visits, diagnostic procedures, or therapeutic treatments:

1. Member has not spoken to PCP: If a member informs the Health Plan that they want to have a service and they have not spoken with their PCP about this request, Member Services will direct the member to make an appointment with the PCP's office to discuss this service.

2. Member has spoken with PCP: If the member informs the Health Plan that they have already spoken with the PCP or the PCP's office about the service, our Member Services Department will send the information to the UM Department to begin the decision process.

    - The UM department will make up to three attempts to obtain a decision from the PCP. UM will call and fax the PCP's office about the request and will include information on the service(s) that the member is requesting. In order to ensure rapid authorization turn-around-times, the PCP should respond on the same day, especially if the request is expedited.

    - The final determination will be communicated to the member and the PCP office either verbally or in writing, depending on the decision.

Specialist or Provider Requests to Health Plan for Decision on Services

This section does not apply to counties with limited Medical Home. When the Utilization Management Department receives a request for services directly from a specialist or provider other than a PCP:

- UM will call the member's PCP office to inform the staff of the request and will also fax the information about the request received from the specialist or other provider.

- The UM department will make up to three attempts to obtain a decision from the PCP. UM

will call and fax the PCP's office about the request and will include information on the service(s) that the specialist is requesting. In order to ensure rapid authorization turn-around-times, the PCP should respond on the same day, especially if the request is expedited.

- Our goal is to complete all standard organizational determinations within 5 days. If a PCP response is not received timely, the UM Department will contact the PCP a second time.

- If no recommendation is received from the member's PCP after three attempts, the request and information will be forwarded to the Health Plan's Medical Director for a final decision.

Criteria

The Utilization Management Department utilizes the following criteria when making a determination:

- Center for Medicare and Medicaid (CMS) National Coverage Determinations
- CMS Local Coverage Determinations
- InterQual
- Hayes Medical Technology
- Local Health Plan Coverage Guidelines

For a copy of the specific UM Review Criteria, please contact the UM Department, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

The Health Plan's Medical Director also has access to an external independent review agency, which consist of board-certified specialists for consultation on issues that fall outside of his/her expertise.

Medically Necessary Services or Medical Necessity – These are services provided in accordance with 42 CFR Section 440.230 and as defined in Section 59G-1.010(166), F.A.C., to include that medical or allied care, goods or services furnished or ordered must:

A. Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.

3. 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.

4. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

B. "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

C. The fact that a provider has prescribed, recommended, or approved medical or allied goods or services, does not make such care, goods or services medically necessary, a medical necessity or a covered service.

Approved Requests

When a pre-service authorization request is approved, an authorization notification will be faxed to the PCP and the requesting provider(s). This notice will contain the valid timeframe of the authorization, the date of the decision, who requested the authorization, who is authorized to provide the services and which services were authorized. The PCP or provider are delegated the responsibility of notifying the member of the approval and arrange the needed services. The member will also receive a letter or verbal notification notifying them of the approved authorization.

Pended Requests

When the pre-service authorization request is pended, the UM Department may contact the provider to gather additional information. The requests will be either verbal or faxed to the provider's office.

Each request has a specific timeframe for response and will also inform the provider of what is required. If the provider does not respond to the request and the Medical Director is unable to approve based on the clinical information available, the appropriate denial letter will be mailed to the member and faxed to the providers.

Denied Requests

If a service is denied, the member, PCP, and provider will receive a CMS-developed form that informs all parties of the reason for the denial, the criteria on which the decision was based, how to

access a copy of the criteria, and appeal rights. This letter will also provide contact information for the Health Plan's Medical Director in the event that the provider would like to discuss the case further. If two business days elapse since the denial letter issued, any further action on the request will be handled through the appeals process, which is explained in this manual.

The Health Plan will comply with all Federal and State requirements concerning denial of services. The Health Plan's Medical Director and UM staff are available during normal business hours to assist providers with inquiries regarding a service denial or to provide a copy of the criteria used to make the determination. Providers should contact the UM Department by calling the number listed at the beginning of this section.

Emergency and Urgent Care Services

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

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

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider who is qualified to perform emergency services.
- Needed to evaluate or stabilize an emergency medical condition.

Urgently needed services are covered services that:

- Are not emergency services as defined in this section.
- Are provided when a member is temporarily absent from the Health Plan's service area. (Note that urgent care received within the service area is an extension of primary care services).
- Are medically necessary and immediately required, meaning that:
    - The urgently needed services are a result of an unforeseen illness, injury, or condition; and
    - Given the circumstances, it was not reasonable to obtain the services through the

Health Plan's participating provider network.

Note that under unusual and extraordinary circumstances, services may be considered urgently needed when the member is in the service or continuation area, but the Health Plan's provider network is temporarily unavailable or inaccessible.

Pharmacy and Provider Access during a Federal Disaster or Other Public Health Emergency Declaration

The Health Plan will consult the U.S. Department of Homeland Security Federal Emergency Management Agency's (FEMA's) website (see www.FEMA.gov) for information about the disaster or emergency declaration process and the distinction between types of declarations. The Health Plan will also consult the Department of Health and Human Services (DHHS) or Centers for Medicare & Medicaid Services (CMS) websites for any detailed guidance.

In the event of a presidential emergency declaration, a presidential (major) disaster declaration, a declaration of emergency or disaster by a governor, or an announcement of a public health emergency by the Secretary of Health and Human Services Cost & MA plans - absent an 1135 waiver by the Secretary: The Health Plan will:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A/B benefits must, per 42 CFR § 422.204(b)(3), be furnished at Medicare-certified facilities).
- Waive in full, or in part, requirements for authorization or pre-notification.
- Temporarily reduce plan approved out-of-network cost sharing amounts.
- Waive the 30-day notification requirement to members provided all the changes (such as reduction of cost sharing and waiving authorization) benefit the enrollee.
- Waive the early refill edit on prescription refills.

Concurrent Review & Discharge Health Planning

The Utilization Management Department (UM) maintains an active hospital management program comprised of concurrent review and discharge planning. Key to the success of these efforts is the involvement of the member's PCP.

Upon notification of an emergency admission, and receipt of the necessary clinical information, the Health Plan will establish medical necessity and notify the appropriate provider. The Health Plan will also notify the member's PCP via fax of the member's admission (if the PCP is not the admitting physician).

Discharge planning is key to achieving the best outcomes for our members and requires active participation of the facility and physicians involved in their care. To discharge any member to a skilled nursing facility, approval must first be obtained from the Health Plan's UM Department. Patients can be admitted to a skilled nursing facility directly from the emergency department, their home or from an inpatient or observation stay in an acute care facility.

The UM Department staff will assist in coordinating any post-discharge services with participating ancillary providers, including referring members for Disease Management and/or Case Management services.

Covered Services

Health Plan members are eligible for all Medicare covered services, as appropriate. The Health Plan also offers a variety of added benefits to its members. To learn more about an individual member's covered benefits, please use one of these three resources:

Be sure to search the Health Plan's web eligibility verification tool or contact Member Services to find member-specific benefits.

Medicare: Search the CMS Medicare Coverage Database that is available online at: http://www.cms.hhs.gov/mcd/overview.asp Below is a summary of covered services by Medicare.

Summary of Medicare Part A Covered Services - (Inpatient Care – see restrictions in Medicare coverage database)

- Anesthesia
- Chemotherapy
- Room and board
- All meals and special diets
- General nursing
- Medical social services
- Physical, occupational, and speech-language therapy
- Drugs with the exception of some self-administered drugs
- Blood transfusions
- Other diagnostic and therapeutic items and services
- Medical supplies and use of equipment

- Respite care in hospice
- Transportation services
- Inpatient alcohol or substance abuse treatment
- Part A blood (see the restrictions under non-covered services)
- Clinical trials (Inpatient)
- Kidney dialysis (Inpatient)

Summary of Medicare Part B Covered Services - (Medically-Necessary Outpatient Services – see restrictions in Medicare coverage database)

- Durable medical equipment (DME)
- Home health services
- Outpatient physical, speech, and occupational therapy services
- Chiropractic care
- Outpatient mental health services
- Part B blood
- Physician services
- Prescription drugs
- Preventive care services
- X-rays and lab tests

Direct Access Programs

The Health Plan maintains written case management and continuity of care protocols that include a mechanism for direct access to specialists for members identified as having special health care needs, as is appropriate for their condition and identified needs.

Members have direct access to dermatologists, podiatrists, chiropractors, ophthalmologists, optometrists, and behavioral health providers, among others. Our Member Services Department will provide assistance on how to find the appropriate provider.

Dermatology Services

Members have direct access without a referral to network dermatologists for the first five visits each calendar year. In order to receive payment, services must be both medically necessary and covered

benefits. Dermatologists are expected to utilize participating laboratories unless otherwise established in the provider's contract. Members are covered through the Medicare guidelines. The Health Plan pre- certifies MOHS procedures only.

Podiatry Services

Medicare members have direct access without a referral to network podiatrists through a statewide contract. In order to receive payment, services must be both medically necessary and covered benefits. Podiatrists are listed in the Health Plan's Provider Directory. Refer to the Statute for visit limitations. Members are covered through the Medicare guidelines.

Chiropractic Services

Chiropractic services are available to members of all lines of business through a statewide contract. Members may contact the network provider directly to access services that are both medically necessary and covered benefits. A list of network chiropractors is in the health plan's Provider Directory.

Ophthalmology/ Optometric Services

Medical eye care services are available to members of all lines of business through a statewide contract. Members may contact a network optometrist directly for routine vision screening and medically necessary covered benefits. If the optometrist determines that the member needs to be seen by an ophthalmologist, the optometrist should contact the Statewide vendor, and an authorization is granted for an in-network ophthalmologist.

If a PCP determines that there is a medical eye problem, and deems it medically necessary for the member to be seen immediately by an ophthalmologist, the PCP should call the Health Plan's Member Services line at 1-800-401-2740, TTY: 711 (Freedom Health) or 1-866-245-5360, TTY: 711 (Optimum HealthCare), Monday through Friday from 8:00 a.m. until 5:00 p.m. EST. The PCP may also have the member call Member Services to find the nearest ophthalmologist to handle the member's care.

Vision Services

The Health Plan has a discounted vision benefit for frames, lenses and contact lenses. A list of network vision providers is in the Health Plan's Provider Directory.

Behavioral Health Services

Behavioral health services are available through a statewide contract. Members may self-refer to a participating behavioral health provider and schedule an appointment by calling the toll-free

number available in the Health Plan's Provider Directory. Providers who want to coordinate care on behalf of the member may call the Health Plan's toll-free number.

Well Woman – Routine & Preventive Services

Members have direct access to network women's health specialists for routine and preventive services. The Health Plan will reimburse network physicians for procedure when billed with diagnosis code DX Z01.41 without prior authorization or physician referral.

Initial Health Assessment Tool (HAT), also known as Health Risk Assessment

Members receive an Initial Health Assessment Tool along with a self-addressed stamped envelope for return shortly after becoming effective with the Health Plan. The responses on these assessments may lead to the following:

- Referral to social services for members who demonstrate functional or behavioral needs for further assessment.

- Intervention by a nurse from the Case and Disease Management Department to assist in coordination of care.

By receiving the completed Health Risk Assessments, the Health Plan is able to risk-stratify and identify members who would benefit from interventions and care coordination activities performed by a nurse and/or social worker. Our goal is to identify all members who need help. However, some members experience barriers that prevent them from completing and returning a Health Risk Assessment Tool. We hope to partner with our providers to facilitate successful completion and return of the assessment tools. Using the Health Risk Assessment Form found in section 10, we encourage our providers to remind or assist members to complete it and send it back to the Health Plan. Forms completed in the office may be faxed to the Special Needs Plan Department at 1-813-506-6153.

Disease Specific Assessment

When a Medicare member states that he/she has one of the diseases listed below, a Disease Specific Assessment is sent to the member in order to determine the level of wellness in each of the specific diseases. There are Disease Specific Assessments for the following diseases:

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Cardiovascular Disease

- Congestive Heart Failure

The responses to these assessments allow the Health Plan to risk stratify the member for enrollment into the Disease Management Program (see Disease Management Programs and Special Needs Health Plans below).

Clinical Practice Guidelines

The UM program is built on evidence-based medicine. To support this premise, the Health Plan has adopted a set of clinical practice guidelines, which are:

- Based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.
- Considerate of the needs of the members.
- Adopted in a consultation with providers.
- Reviewed and updated periodically, as appropriate.

A copy of our clinical practice guidelines is on the Health Plan's website. If you would like a copy of a particular guideline, you may call the UM Department and place a request or fax the request to the UM fax number including which guideline you need and the address where it should be sent. The Quick Reference Guide has a list of these and other important Health Plan numbers.

Case Management Program

The purpose of the Case Management Program is to achieve and maintain member wellness through advocacy, communication, education, timely identification and facilitation of services. The Health Plan has developed a Case Management Program that assists members who may have experienced an acute event or have other complex health issues:

- Wounds
- Transplants
- Multiple hospital admissions for the same or a related diagnosis
- Major system failure
- Multiple traumas
- Head or spine injuries with severe deficits
- High hospital emergency department utilization
- Cancer

- Multiple comorbidities

Members are identified for the Case Management Programs through several sources, including, but not limited to:

- Claim or encounter data
- Laboratory results
- Pharmacy claims data
- Information from UM services
- Discharge planning from acute or skilled services
- Member self-referral
- Physician or provider referral
- Information gathered from responses on the member Health Assessment Tool
- Self-enrollment request through the Member Portal

Member participation in the Case Management Program is voluntary and a member may choose to opt out of participation at any point in the process. Provider support of the case management process is encouraged as the Health Plan seeks to reduce acute care readmissions, as well as facilitate assistance in closing care gaps affecting the successful implementation of treatment plans.

The Complex Case Managers and Disease Case Managers are Registered Nurses who work closely with the member, the member's family and provider/professional staff in the development of a mutually agreed upon Care Plan. The Case Manager will seek to understand the provider's plan of care. This is to better assist the member in reaching the established goals developed in this plan of care and will be in frequent communication with the member's physician regarding the member's progress. To request possible enrollment or an evaluation of your member into Case Management, call the Case and Disease Management Department at 1-888-211-9913, or fax a "Case/Disease Management Referral" form to 1-888-314-0794. This form can be found in section 10 of the Provider Manual or on the Plan's website under the Tools and Resources section of the providers tab.

Disease Management Programs

Disease Management Programs are designed to assist in preventing disease complications or exacerbations, enhance member self-management, and reduce acute episodes. This is provided through assessment, education, and health coaching for Health Plan members who share a common diagnosis. The Health Plan has determined that the following diseases are indicative of the needs of the Health Plan's population:

- Diabetes
- Cardiovascular Disease.

Members are identified for Disease Management Programs through several sources, including, but not limited to:

- Claim or encounter data
- Laboratory results
- Pharmacy claims data
- Information from UM services
- Discharge planning from acute or skilled services
- Member self-referral
- Physician or provider referral
- Information gathered from responses on the member Health Assessment Tool
- Self-enrollment request through the Member Portal

Member participation in the Disease Management Program is voluntary and a member may choose to opt out of participation at any point in the process. Provider support of the case management process is encouraged as the Health Plan seeks to reduce acute care readmissions, as well as facilitate assistance in closing care gaps affecting the successful implementation of treatment plans.

To request enrollment or an evaluation for possible enrollment for a patient into a Disease Management Program, call the Case and Disease Management Department at 1-888-211-9913, or fax the "Case and Disease Management Referral Form" to 1-888-314-0794. This form can be found in section 10 of the Provider Manual or on the Plan's website under the Tools and Resources section of the Providers tab.

Social Services

The Case and Disease Management Department includes social workers who have experience assisting members with barriers to care, such as psychosocial situations or lack of sufficient resources to participate adequately in their care. Social Services staff work with referred members to identify resources that may be beyond the Health Plan's benefit structure. The staff assists members to apply for government or charitable programs that may help in addressing gaps in care or resources, or difficult psychosocial circumstances.

If you have a patient who needs social services assistance, contact Social Services by calling the Case and Disease Management Department at 1-888-211-9913, or fax the "Case and Disease Management Referral Form" to 1-888-314-0794.

This form can be found in section 10 of the Provider Manual or on the Plan's website under the Tools and Resources section of the Providers tab. Please include all relevant information regarding the referral so that we may assist the member in the timeliest and most appropriate manner.

Special Needs Plans

The Health Plan also offers Special Needs Plans (SNP), which were developed for Medicare or dual-eligible members who will benefit from a specialized benefit structure that assists the member with the management of their condition. The Health Plan offers the following Special Needs Plans:

- A combined health plan for diabetes, cardiovascular disease and congestive heart failure.
- Pulmonary disease health plan.
- Dual-eligible health plan or "DSNP".

Enrollment into a SNP is determined at the time a member requests to participate. They must complete a pre-enrollment questionnaire on which they state that they have one of the diseases mentioned above or demonstrate enrollment in both Medicare and Medicaid. The member's physician must confirm the diagnosis for a disease-specific SNP.

Information from the member's Initial Health Assessment Tool and the Disease Specific Assessment assist the Health Plan in risk stratifying the SNP members into one of three tiers:

Tier 1:

- Have a Care Plan developed that utilizes evidence-based guidelines.
- The member's PCP is responsible for the implementation and outcomes of the Care Plan.

Tier 2:

- Have a Care Plan developed that utilizes evidence-based guidelines and information received from the member's disease specific assessment responses.
- The member's PCP receives a copy of the plan of care and is responsible for its implementation and outcomes.

Tier 3:

- Have a Care Plan developed through the interventions of a clinical case manager who performed a more in-depth assessment.
- This Care Plan is agreed upon by the member, the member's caregiver (if applicable) and the case manager. The Care Plan is shared with the member's PCP.
- The clinical case manager closely monitors the member for success and completion of interventions in order to achieve health care goals.

Please refer to the Care Plan Manual for additional information. If you need a copy of the Care Plan Manual, please contact the Provider Relations Department.

For Health Plan's DSNP plan, Providers servicing the Dual-Eligible population agree to comply with AHCA's Medicaid Services Coverage and Limitations Handbooks, including professional licensure and certification standards and includes the scope of services which can be found at the link below.
https://ahca.myflorida.com/medicaid/Finance/data_analytics/actuarial/docs/Medicare_Advantage_D-SNP_Medicaid_Covered_Services.pdf, and as may be amended from time to time by AHCA and Health Plan. Providers servicing the Dual-Eligible population agree to comply with:

- All applicable Medicare Advantage rules, regulations and policies; and

AHCA's Medicaid Services Coverage and Limitations Handbooks, including professional licensure and certification standards and includes the scope of services which can be found at https://ahca.myflorida.com/medicaid/Finance/data_analytics/actuarial/docs/Medicare_Advantage_D-SNP_Medicaid_Covered_Services.pdf, and as may be amended from time to time by AHCA and the Health Plan.

The Health Plan ensures that providers who deliver care to our SNP members are properly educated in how they can support the unique needs of this population. The Health Plan makes every effort to offer and provide SNP training for all providers. PCPs are required to attest that they have received initial education regarding, Special Needs Plans at the time of orientation and will attest to an annual re-education regarding these services. For PCPs, who fail to complete annual re-education during the annual established deadline, the Health Plan's Provider Relations Representative will schedule a face to face and/or web-based training at an agreed upon date to ensure the re-training is completed. If the re-training is not completed within thirty (30) days, then a Letter of Non-Compliance will be mailed to the PCP. Any non-compliant PCPs are reported to the Health Plan's Compliance Committee. The Compliance Committee, with the participation of the Managing Medical Director and Chief Compliance Officer will make recommendations to the Provider Relations Department when the SNP training has not been completed by the PCP. The

recommendations may include a limited suspension of assignment of members to a PCP, follow-up communication and/or training with the PCP in addition to SNP training, as well as potential termination of the PCP or the contracted entity.

The Model of Care Training includes the following specific content:

- Discussion of the Special Needs Plans offered by the MAO
- Review of the SNP Model of Care key components
- Review of the SNP Model of Care to include Interdisciplinary Care Team, MOC training, Health Assessments, Stratification, Individualized Care Plans, Interdisciplinary Care Team, Benefit Structure, and Communication Network Processes
- Care Management for the most vulnerable SNP population
- Overview of Performance and Health Outcomes Management

The Case Management Program also includes the collaboration of the member's physician(s), providers, and the member/caregiver in order to reach the goals developed in the Care Plan.

Member participation in the Case Management Process is voluntary. The member may decline these services at any time.

For more information on Special Needs Plans please go to the Health Plan's website: www.freedomhealth.com or www.youroptimumhealthcare.com

Preventive Health Guidelines

The Health Plan has adopted the U.S. Preventive Services Taskforce Guidelines, which are annually reviewed to reflect any changes in recommendations regarding screening, counseling and preventive services. These guidelines can be referenced on the website for the Agency of Health care, Research and Quality at: www.ahrq.gov/professionals/clinicians-providers/index.html

The Health Plan recognizes the importance of preventive health and chronic care services that are provided in ambulatory care settings. These services improve members' health and keep rising health care costs under control. Preventive health services can help detect and monitor diseases in earlier stages and therefore, avoid disease progression.

These preventive and ambulatory services increase the number of PCP and outpatient visits, which help the members, avoid unnecessary trips to the hospital emergency room (ER). Preventing hospital ER visits, when possible, ultimately results in a reduction of hospital readmission rates. Hospital care is not only expensive, but it is not always the best care setting for the elderly. Frequent hospitalizations present a gap in care that can help identify opportunities for improvement. Utilizing preventive and ambulatory care services help members live longer healthier lives.

The Health Plan updates its network providers regularly regarding adopted preventive health standards. We also provide these guidelines to our members to help them stay current with preventive health screenings and tests. Throughout the year, we send information to our members through individualized mailings as well as member newsletters, which discuss recommended preventive screenings. Recommendations may be based on age and gender. They can also be based on other risk factors and health conditions.

Financial Incentives

Freedom Health and Optimum HealthCare make utilization management decisions based only on appropriateness of care and service, in conjunction with member benefits and coverage. The Health Plan does not reward practitioners or other individuals for issuing denials of coverage or care. The Health Plan does not encourage or provide incentives regarding utilization management decisions that result in underutilization of health care services.

Diabetic testing Meters and Test Strips

A member who is newly diagnosed with diabetes and needs a diabetic testing meter and test strips may:

- Order their diabetic supplies by visiting the Member Portal website (www.freedomhealth.com or www.youroptimumhealthcare.com) or by calling us at 1-866-900-2688 • TTY: 711 (Freedom Health and Optimum HealthCare).

Members pay $0 for diabetic monitors, lancets and test strips through the plan mail order program. (Authorization and/or a prescription may be required.) Compare to pharmacy retail cost of 20%. (Coinsurance amount for retail supplies varies by plan). The Member's supplies will be mailed direct at NO COST TO THEM.

6. MEDICATION MANAGEMENT

Introduction

The Health Plan has developed a Formulary to promote clinically appropriate utilization of medication, in a cost-effective manner.

The drugs on the Health Plan's Formulary are set up in a tier system that offers providers and members a choice of medications. Generic medications listed will have the widest choice and the least co-payment. Brand medication options could be limited in certain classes or may not be available on the Health Plan.

The Health Plan's Clinical Pharmacy Committee meets quarterly to review and recommend medications for Formulary consideration. The Clinical pharmacy Committee is comprised of the Health Plan's Medical Director, Pharmacy Director, Clinical Pharmacy Operations Manager, pharmacist, and physicians from our provider network. Providers can request the addition of a drug to the Formulary by writing to the Health Plan's Medical or Pharmacy Director.

Physicians interested in participating in our Clinical Pharmacy Committee should contact our Medical Director or Pharmacy Director.

Formulary

The Health Plan has its own Formulary, a listing of medications intended to assist the Health Plan's physicians and pharmacy providers in delivering comprehensive, high quality, and cost-effective pharmaceutical care. The Formulary is posted on the Health Plan's website at www.freedomhealth.com and www.youroptimumhealthcare.com. Printed copies are also available by calling the Health Plan's Provider Relations Department at 1-800-401-2740.

The Formulary only applies to outpatient medications that are filled at network pharmacies and does not apply to inpatient medications or those obtained from or administered by a physician. Typically, most injectable drugs, except those listed on the Formulary, are not covered by the pharmacy benefit. These must be approved through the Utilization Management Department.

Generic Substitution

Generic drugs, excluding those with a narrow therapeutic index, should be dispensed when available. The Food and Drug Administration (FDA) has approved a selection of 'generic equivalents' for branded medications. Generic substitution is mandatory when an "A" or "AB" rated generic drug is available. Drugs listed on the State Negative Formulary are exempt from generic substitution requirements.

Drugs Not on the Formulary

Medications not on the Formulary are not a covered benefit. A drug exception can be requested when a medication is not on the Formulary by using the Prior Authorization/Coverage Determination Request Form and providing the related clinical information. Approval is based on the member's medical and prescription benefits coverage, acceptable medical standards of practice and FDA-approved uses.

A provider or a member may request the addition of a drug to the Formulary by sending a letter to

the Health Plan's Medical Director that specifies which medication and why it should be added. These requests are reviewed by the Clinical Pharmacy Committee.
Physicians interested in participating in the Clinical Pharmacy Committee should contact our Managing Medical Director.

Prior Authorization (PA) / Step Therapy (ST)

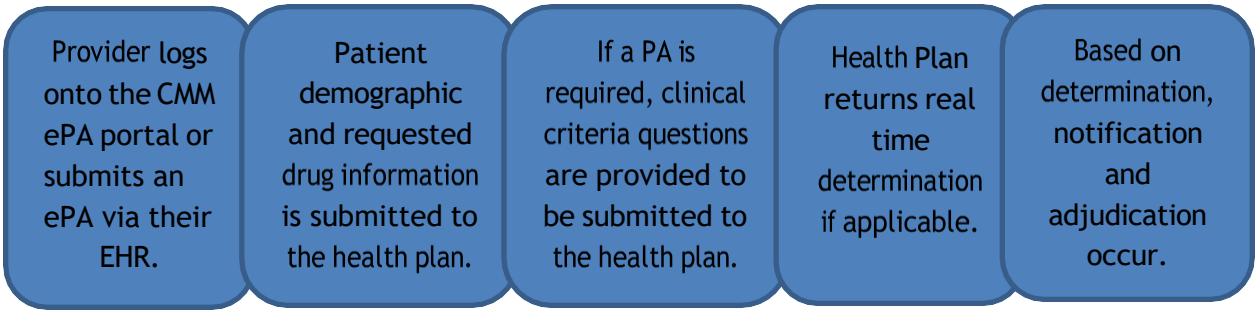
Some drugs on the Formulary may have a designation of PA, meaning prior authorization is required. These are drugs that will require the provider to send in a request to the Health Plan to cover this medication. Medical documentation, including any labs, tests, diagnosis, and/or previous medications failed, may be needed for the request to be considered.

There are some drugs that would require the use of first line drugs before the drug being prescribed would be approved; this is called Step Therapy. Documentation that the first line drugs have been tried and failed or are not tolerated by the patient needs to be submitted with the Prior Authorization/ Step Therapy Request before the request can be considered. The Prior Authorization/Step Therapy Criteria Form can be found in the Forms section of this manual.

Requesting a coverage determination through ePA

ePA provides a self-service alternative for providers to electronically communicate with a patient's Health Plan in order to determine if a PA is required, and then to initiate, complete, and manage PA requests via a web portal.

The following flow chart demonstrates possible ePA pathways for prescribers to submit and complete an ePA:



ePA cases are simply initiated in a manner which is different from phone and fax cases. Once the case is submitted to Elevance Health (CarelonRx) the workflow is the same. Additionally, an immediate approval decision can be communicated back to the provider if the clinician provides the necessary information to meet the clinical criteria during the online ePA process.

ePA is currently available for Elevance Health providers through CoverMyMeds for Medicare members in all states, and Medicaid members in many states including: IN LA, CA, TX, KS & SC.

Quantity Limits

Many drugs contain quantity limits, which restrict the amount of the particular medicine dispensed as a benefit from the Health Plan. These are typically limited to a one (1) month supply. Some categories of drugs include:

- Sedative/hypnotics
- Impotence medication
- Certain antihypertensive medication
- Other type of quantities limits which address medical issues

If the provider needs an exception to the quantity limits because of medical necessity, he/she should follow the process described in the "Drugs not on the Formulary" section.

Co-payments

The Formulary is categorized into four/five tiers as described below. The co-payment varies with each category. The preferred generic tier has the lowest co-payment, and the non-preferred brands/generics have the highest. Brands that do not appear on the Formulary are not covered.

Enhanced Formularies

Tier 1: Generic and Brand

Tier 2: Non-Preferred Generic and Preferred Brand

Tier 3: Non-Preferred Generic and Non-Preferred Brands

Tier 4: Specialty Drug

Diabetic Formularies

Tier 1: Generic and Brand

Tier 2: Non-Preferred Generic and Preferred Brand

Tier 3: Non-Preferred Generic and Non-Preferred Brands

Tier 4: Specialty Drug

Tier 5: Select Diabetic Drugs

Self-Injectables, Home Infusion and Physician Administered Drugs

Most injectable drugs of all types require authorization through the Prior Authorization / Coverage

Determination Request process with the following exceptions:

- One-time antibiotics.
- Intra-articular injections of steroids.
- Intravenous or intra-muscular injection of steroids.

To request a Physician Administered Drug, please use our Specialty Medication Request Form found in the appendix or visit the Health Plan's website at:

www.freedomhealth.com/provider/tools_and_resources/forms
www.youroptimumhealthcare.com/provider/forms.

For a full list of drugs on the formulary, please visit the Health Plan's website at:

https://www.freedomhealth.com/medicare/pharmacy_and_part_d#formulary
https://www.youroptimumhealthcare.com/medicare/pharmacy_and_part_d#formulary

Pharmacy Use

All members should use network pharmacies. A list of participating pharmacies is in the Provider Directory. If a member uses a non-network pharmacy, the medication may not be covered. Members may use out-of-area pharmacies for emergencies only. Our members are encouraged to receive electronic refill reminders for ease and adherence. We encourage our providers to discuss this beneficial feature with their patients. Our hope is to make refills easy in an effort to increase adherence.

Medication/treatment compliance surveillance is designed to:

- Monitor and enhance medication treatment compliance among members.
- Monitor and evaluate medication treatment patterns among providers.
- Identify potential negative effects of medication treatment, to include drug-to-drug interactions, contraindications, and medication side effects.

Drug Utilization Review Program

To promote safe and cost-effective utilization, selected high-risk, high cost, specialized use medications, or medications not included on the Health Plan's Formulary require a Prior Authorization/ Coverage Determination Request. Approval is granted for medically necessary requests and/or when Formulary alternatives have demonstrated ineffectiveness. An electronic form for this request is available on our websites at www.freedomhealth.com and www.youroptimumhealthcare.com > Pharmacy & Part D > Coverage Determination Request Form.

When these exceptional needs arise, the physician should submit a Coverage Determination Request Form to the Health Plan. Approval for use is based on the member's medical and prescription benefit coverage, acceptable medical standards of practice and FDA-approved uses. For questions related to a Coverage Determination Request, contact the Utilization Management Department at 1-800-401-2740.

Retrospective Drug Utilization Review

Retrospective Drug Utilization Review is conducted for our partner Physician IPAs, making recommendations on drug use, patterns and polypharmacy on an as needed basis.

Medication Therapy Management (MTM)

Medication Therapy Management is a service provided by healthcare providers to ensure patients are receiving optimal therapeutic benefit from their medication use. It is an interactive discussion, face to face or over the phone, between the healthcare provider and the patient, during which the patient's prescription and over the counter medications are discussed in detail. The comprehensive review enables the healthcare provider to evaluate compliance, identify potential drug interactions, gaps in therapy, medication side effects, and cost saving opportunities for the patient. There are five main components of the comprehensive medication review: the medication therapy review, a personal medication record, a medication related action plan, recommendations to the member's provider, as well as documentation and follow up.

The Health Plan's 2024 CMS contract authorizes Pharmacists, Physicians, ARNPs, and Physician Assistants to complete MTM services for our members, although the completion of a comprehensive medication review with a pharmacist is preferred.

7. QUALITY MANAGEMENT PROGRAMS

Overview

The Health Plan has established a Quality Management (QM) Program designed to comply with state and federal regulations and to promote quality care and service for our members. The QM Program also provides a system for improving organizational processes. Provider contracts require participation in the Health Plan's QM Program.

The ongoing QM Program is based on the guiding quality principle of Continuous Quality Improvement (CQI), where performance improvement results from ongoing and systematic measurement, intervention and follow-up of key clinical and non-clinical aspects of care. The QM Program includes the use of performance data available through standardized measures, state and national benchmarks and root cause analyses that relate to measuring outcomes and identifying opportunities for improvement.

Analytical resources are available through Quality Management staffing and through the employment of project-specific consultants. Our staff has access to end-user data-systems for data including quality, claims/encounters, enrollment utilization, appeals and grievances, credentialing and member services to provide information for performance measures and quality improvement activities.

The QM Program is available through the Health Plan website's Quality Management section. This section includes information about the Health Plan's progress toward meeting quality management goals. Providers are encouraged to review the website regularly for current program information and updates. A printed copy of the QM Program is available, upon request, to providers and members.

Goals/Objectives

Program goals are to:

- Improve and maintain Plan member's physical and behavioral health status.
- Promote health, risk identification and early interventions.
- Empower members to develop and maintain healthy lifestyles.
- Involve members in treatment and care management decision-making.
- Facilitate the use of evidence-based medical principles, standards and practices.
- Promote accountability and responsiveness to member concerns and grievances.
- Coordinate utilization of medical technology and other medical resources efficiently and

effectively for member welfare.

- Facilitate timely member access and availability to care.
- Promote member safety in conjunction with effective medical care.
- Provide culturally and linguistically competent health care delivery and promote health care equity.

The Health Plan Quality Management Program components include:

- Member rights and responsibilities
- Member satisfaction
- Access and availability
- Appeals and Grievance
- Utilization management
- Disease and Complex case management
- Medical record review and practices
- Credentialing and re-credentialing
- Peer review
- Clinical Quality Improvement Initiatives
- Operational Quality Improvement Initiatives
- Chronic Care Improvement Program
- Risk Management
- Member safety program
- Delegation oversight
- Member and provider communication
- Confidentiality of member information
- Behavioral health
- Cultural competency
- Quality of Care
- Health Information System
- Data Integrity, Accuracy and Completeness
- QMP Integration of Health Information
- HIPAA and Privacy Law Compliance
- Quality Data Reporting
- Preventive health and HEDIS Reporting
- Health Outcomes Survey Reporting
- CAHPS Survey Reporting
- Part C Reporting

- Part D Reporting
- Coordination and continuity of care, including medical and behavioral health
- Monitoring of delegated services

Primary objectives of the Quality Management Program to support these goals include:

- Proactively pursue methods to improve care and service to members.
- Develop interventions to improve overall health of members.
- Develop systems to enhance coordination and continuity of care between medical and behavioral health services.
- Maintain systematic identification and follow-up of potential quality issues
- Educate members, physicians, hospitals, and ancillary providers about the Plan's quality management goals, objectives, structure, and processes.
- Promote open communication and interaction between and among providers, members, and the Plan.

The Quality Management Program is evaluated and updated at least annually with input from Health Plan staff, network providers and members. The Quality Management Program includes a committee structure designed to review and monitor medical management, quality management, Clinical Pharmacy, credentialing, peer review, and grievances/appeals activities.

Providers who wish to participate in any of these committees are encouraged to notify the Health Plan for consideration. A company-wide quality steering committee oversees all quality related activities and reports to the Board of Directors.

Provider Notification of Changes

The Health Plan will notify physicians and providers of material changes in writing, 30 days prior to putting the changes into effect. These changes are communicated via the Health Plan websites. Provider Manual and/or the Provider Newsletter.

A "material change" is a change that may influence a physician or provider's decision to remain in the Health Plan's network. Examples of material changes are those that affect the organization's payment structure, the size of member panels, or the scope of a physician and/or provider's administrative responsibilities.

Please contact the health plan's local Provider Relations representative should you have questions related to a change notification.

Medical Health Information

Participating providers are expected to provide information to Health Plan members regarding their health status and treatment options, including self-treatment. This information should include the risk, benefits, and consequences of treatment or non-treatment. Providers should also allow members to participate in treatment decisions and to refuse treatment. Members have the right to ask for a written summary of their health conditions and treatment plan, which providers are expected to provide.

Medical Record Standards

In accordance with the Health Plan's Physician Service Agreement, the physician shall ensure medical records are accurately maintained for each member. It shall include the quality, quantity, appropriateness, and timeliness of services performed under this contract.

Medical records shall be maintained for a period of no less than ten (10) years, including after termination of this agreement and retained further if records are under inspection, evaluation, or audit, (including medical records and documentation of physician services related to any DSNP services provided by physician), until such audit is completed or such other time period as required by law or regulation.

Upon request, the Health Plan, AHCA or any other federal or state regulatory agency, as permitted by law, may obtain copies and have access to any medical, administrative, operational or financial record of physician-related and medically necessary covered services provided to any member. The physician further agrees to release copies of medical records of members discharged from the physician to the Health Plan for retrospective review and special studies.

A medical record documents a member's medical treatment, current and past health status and current treatment plans. A member's medical record is an essential component in the delivery of quality health care. The Health Plan has established medical record standards available to all participating practitioners. Providers are required to comply with these standards.

Medical Record Standards

- Every page in the record contains the member's name, member ID number, and birth date.
- Includes personal/biographical data including age, date of birth, sex, address, employer, home and work telephone numbers, marital status and legal guardianship.
- The record reflects the primary language spoken by the member and any translation needs of the member.

- All entries are signed and dated.
- All entries include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider.
- All entries in the medical record contain legible author identification. Author identification is a handwritten signature, or an electronic signature authentication. Signature is accompanied by the author's title (MD, DO, APRN, PA, MA). Stamped signatures are not permissible. The Author of the record is required to "Sign" a paper chart or "Close", authenticate, and seal Electronic Medical Record.
- The record is legible to someone other than the writer.
- The record is maintained in detail.
- Medication allergies and adverse reactions are prominently noted in the record. If the member has no known allergies or history of adverse reactions, this is noted in the record (no known allergies = NKA).
- Past medical history easily identified and includes serious accidents, significant surgical procedures, and illnesses.
- Includes previous physicals.
- Immunization record is current.
- Diagnostic information, consistent with findings, is present in the medical record.
- A treatment plan, including medication information, is reflected in the medical record.
- A problem list including significant illnesses, medical conditions, health maintenance concerns and behavioral health issues are indicated in the medical record.
- Medical record includes a medication list; indicating adjustments, discontinued medications, initialed/signed off, and dated by the provider of services correlating to the date of service.
- Notation concerning the use of cigarettes and alcohol use and substance abuse is present.
- If a consultation is requested, a note from the consultant is in the record.
- Emergency room discharge notes and hospital discharge summaries (hospital admissions which occur while the member is enrolled and prior admissions, as necessary) are appropriately and medically indicated in the medical record.
- The record includes all services provided including, but not limited to, family planning

services, preventive services and services for the sexually transmitted diseases.

- There is evidence that preventive screening and services are offered in accordance with the Health Plan's care preventive services, policies, procedures, and guidelines.
- The record contains evidence of risk-screenings.
- The record contains documentation that the member was provided with written information concerning member's rights regarding advance directives and whether or not the individual has executed an advance directive; documentation is to be displayed in a prominent location in the record.
- The record documents members seeking assistance with special communications needs for health care services.
- Documentation of individual encounters includes adequate evidence of:
    - The history and physical expression of subjective and objective presenting complaints, including the chief complaint or purpose of the visit.
    - Medical findings or impressions of the provider, as well as provider's evaluation of the member.
    - Diagnosis.
    - Treatment plan.
    - Laboratory and other diagnostic studies used, or ancillary services ordered.
    - Therapies, home health and prescribed regimens.
    - Encounter forms or notes regarding follow-up care, calls or visits.
    - Unresolved problems from previous visits.
    - Lab, imaging and other diagnostic reports filed in the chart and initialed by the PCP to signify review.
    - Reports from specialists and other consultative services referred by PCP.
    - Discharge reports from hospitalizations.
    - Disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services.
- Medical records are secured in a safe place to promote confidentiality of member information.
- Records are maintained in a location with access limited to authorized staff.
- Records are readily available for provision of care.

- Medical records and all member information are maintained in a confidential manner.
- Additional medical record recommendations include:
    - All entries are neat, legible, complete, clear, and concise, and written in black ink.
    - Entries are dated and recorded in a timely manner.
    - Records are not altered, falsified, or destroyed.
    - Incorrect entries are corrected by drawing a single line through the error.
    - Avoiding correction fluid or markers that will obscure writing.
    - Dating and initialing each correction.
    - Making no additions or corrections to a medical record entry if a medical chart has been provided to outside parties for possible litigation.
    - All telephone messages and consent discussions are documented.

Assessing the Quality of Medical Record Keeping

The Health Plan will assess practitioner compliance with these standards and monitor the processes used in their offices. The Health Plan establishes performance goals for compliance with our medical record documentation standards.

Improving Medical Record Keeping

If a provider does not meet Medical Record Standards, both Provider Relations and Quality Management staff will work with the provider to improve medical record keeping. The Health Plan may send suggestions to practitioners with identified deficiencies on how to improve their medical record-keeping practices, record-keeping aids or examples of best practices that meet the Health Plan's record-keeping standards.

Other Recommended Guidance

Members that voice a concern related to an alcohol dependency issue, or exhibit sign, symptoms, or a clinical history of unhealthy alcohol use should receive a standardized tool assess any potential alcohol use related issue. Based on the member score the provider would recommend a treatment plan.

- In many cases, treatment of alcohol misuse is focused on addressing alcohol dependency and not on at-risk drinking. However, the prevalence of risk drinking is much higher than that of more severe disorders.

- Heavy drinkers who have not had a "crisis" may not seek assistance with alcohol cessation if they do not perceive that their condition is severe enough. In many cases, treatment of alcohol misuse is focused on addressing alcohol dependency and not on at-risk drinking. However, the prevalence of risk drinking is much higher than that of more severe disorders.

Members that currently use tobacco containing products should have a detailed history of use documented in medical records. The physician should discuss tobacco cessation options/strategies pertinent to the members including the use of medication when appropriate.

Medical Record Review

The Health Plan adheres to the Privacy Rule established by the Health Insurance and Portability Act of 1996 (HIPAA) which outlines national standards to protect individuals' medical records and other personal health information. The rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. It also gives rights to patients over their health information, including rights to examine and obtain a copy of their health records and to request corrections.

To ensure HIPAA compliance, the Health Plan performs medical record audits during medical record evaluations. Medical records are reviewed for compliance with documentation requirements as outlined by regulatory and accreditation agencies. They are also evaluated for compliance with preventive, chronic and acute health care standards. Providers who do not meet the Health Plan's standards for medical record documentation will be referred to the Medical Director for follow-up or to the Quality Management Committee for further action.

Medical Record Privacy & Confidentiality Standards

Medical Record Privacy and Confidentiality Standard 1

All Health Plan members' individually identifiable information is confidential whether contained in the member's medical record or otherwise. Such confidential information, whether verbal or recorded, in any format or medium, includes but is not limited to, a member's medical history, mental or physical condition, diagnosis, encounters, referrals, authorization, medication or treatment, which either identifies the member, or contains information that can be used to identify the member.

Medical Record Privacy and Confidentiality Standard 2

In general, medical information regarding a member must not be disclosed without obtaining written authorization. The member, the member's guardian, or conservator must grant the

authorization. If the member signs the authorization, the member's medical record must not reflect mental incompetence. If authorization is obtained from a guardian or conservator, evidence such as a Power of Attorney, Court Order, etc. must be submitted to establish the authority to release such medical information.

Medical Record Privacy and Confidentiality Standard 3

To release member medical information, the requesting entity must use a valid and completed Medical Information Disclosure Authorization Form, prepared in plain language. The form must include the following:

- Name of the person or institution providing the member information.
- Name of the person or institution authorized to receive and use the information.
- The member's full name, address and date of birth.
- Purpose or need for information and the proposed use thereof.
- Description, extent or nature of information to be released identified in a specific and meaningful fashion, including inclusive dates of treatment.
- Specific date or condition upon which the member's consent will expire, unless earlier revoked in writing, together with member's written acknowledgment that such revocation will not affect actions taken prior to receipt of the revocation.
- Date that the consent is signed, which must be later than the date of the information to be released.
- Signature of the member or legal representative and his or her authority to act for the member.
- The member's written acknowledgment that the member may see and copy the information described in the release and a copy of the release itself, at reasonable cost to the member.
- The member's written acknowledgment that information used or disclosed to any recipient other than a Health Plan or provider may no longer be protected by law.
- Except where the authorization is requested for a clinical trial, it must contain a statement that it will not condition treatment or payment upon the member providing the requested use or disclosure authorization.
- A statement that the member can refuse to sign the authorization.

Medical Record Privacy and Confidentiality Standard 4

Pursuant to laws that allow disclosure of confidential medical information in certain specific instances, the Health Plan may release such information without prior authorization from the member, the member's guardian, or conservator for the following reasons:

- Diagnosis or treatment, including emergency situations.
- Payment or for determination of member eligibility for payment.
- Concurrent and retrospective review of services.
- Claims management, claims audits, billing and collection activities.
- Adjudication or subrogation of claims.
- Review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges.
- Coordination of benefits.
- Determination of coverage, including pre-existing conditions investigations (as applicable).
- Peer review activities.
- Risk management.
- Quality assessment, measurement and improvement, including conducting member satisfaction surveys.
- Case management and discharge planning.
- Managing preventive care programs.
- Coordinating specialty care, such as maternity management.
- Detection of health care fraud and abuse.
- Developing clinical guidelines or protocols.
- Reviewing the competency of health care providers and evaluating provider performance.
- Preparing regulatory audits and regulatory reports.
- Conducting training programs.
- Auditing and compliance functions.
- Resolution of grievances.
- Provider contracting, certification, licensing and credentialing.
- Due diligence.
- Business management and general administration.

- Health oversight agencies for audits, administrative or criminal investigations, inspections, licensure or disciplinary actions, civil, administrative, or criminal proceedings or actions.
- In response to court order, subpoena, warrant, summons, administrative request, or similar legal processes:
    - To comply with Florida law relating to workers' compensation.
    - To county coroner, for death investigation.
- To public agencies, clinical investigators, health care researchers and accredited non-profit educational or health care institutions for research but limited to that part of the information relevant to litigation or claims where member's history, physical condition or treatment is an issue, or which describes functional work limitations, but no statement of medical cause may be disclosed.
- To organ procurement organizations or tissue banks, to aid member medical transplantation.
- To state and federal disaster relief organizations, but only basic disclosure information such as member's name, city of residence, age, sex and general condition.
- To agencies authorized by law, such as the FDA.
- To any chronic disease management programs provided that the member's treating physician authorizes the services and care.

Medical Record Privacy and Confidentiality Standard 5

All individual member records that containing information pertaining to alcohol or drug abuse are subject to special protection under Federal Regulations (Confidentiality of Alcohol and Drug Abuse member Records, Code 42 of Federal Regulation, Chapter 1, Subchapter A. Part 2). An additional and specific consent form must be used prior to releasing any medical records that contain alcohol or drug abuse diagnosis.

Medical Record Privacy and Confidentiality Standard 6

Special consent for release of information is needed for all members with HIV/AIDS and mental health disorders. In general, medical information for members who exhibit HIV/AIDS and/or mental health disorders will always be reported in compliance with Florida state law. Authorized consent is required to release any additional information regarding a member infected with the HIV virus.

Information released to authorized individuals/agencies shall be strictly limited to the information

required to fulfill the purpose stated in the authorization. Any authorization specifying "any and all medical information" or other such broadly inclusive statements shall not be honored and release of information that is not essential to the stated purpose of the request is specifically prohibited.

8. CLAIMS

General Payment Guidelines

Claims should be submitted in one of three formats:

- Electronic claims submission
- CMS 1500 form
- UB04 form

Physicians/providers are required to use the standard CMS codes for ICD-10, CPT and HCPCS services, regardless of the type of submission. Claims processing is subject to change based upon newly promulgated guidelines and rules from the Centers of Medicare & Medicaid Services (CMS) and the Florida Agency for Health Care Administration (AHCA).

Medicare General Payment Guidelines

For payment of claims, the Health Plan has adopted all guidelines and rules established by CMS. Medicare members may only be billed for their applicable co-payments, co-insurance, deductibles, and non-covered services.

Mail Claims to:

Freedom Health, Inc.
C/O Claims Processing
P.O. Box 151348
Tampa, FL 33684

Optimum HealthCare, Inc.
C/O Claims Processing
P.O. Box 151258
Tampa, FL 33684

Professional and Technical Component Payments

The Health Plan covers the professional and technical components of global CPT procedures. Therefore, the appropriate professional component modifiers and technical component modifiers should be included on the claim form.

Member Responsibility

The physician or provider should collect the following payments from the member based upon the terms of the physician agreement with the Health Plan and the member's benefit plan design:

- Co-payments
- Deductibles
- Co-insurance

Charges that can be billed and collected from the member will be indicated on the Explanation of Benefits (EOB) notice from the Health Plan. The provider gets an explanation of payment (EOP).

Prohibition of Billing Members

As a participating physician or provider, you have entered into a contractual agreement to accept payment directly from the Health Plan. Payment from the health plan constitutes payment in full, with the exception of applicable co-payments, deductibles and/or co-insurance as listed on the EOB/EOP.

You may not "balance bill" members for the difference between actual billed charges and your contracted reimbursement rate. A member cannot be "balance billed" for covered services denied for "lack of information". Failure to notify the Health Plan of a service that requires prior authorization will result in payment denial. In this scenario, Health Plan members may not be "balance billed" and are responsible only for their applicable co-payments, deductibles and/or co-insurance.

A member cannot be billed for a covered service that is not medically necessary. The member's informed written consent must be obtained prior to rendering a non-covered service. This consent must include information regarding their financial responsibility for the specific services received.

Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those members enrolled in the Qualified Medicare Beneficiary (QMB) Program, including those enrolled in Medicare Advantage and other Part C plans (see Sections 1902 (n)(3)(B), 1902 (n)(3)(C),1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]).

Providers servicing DSNP members must agree to accept Health Plan's Medicare reimbursement as payments in full for services rendered to DSNP Members, or to bill AHCA if Plan has not assumed AHCA's financial responsibility under the DSNP Agreement between Plan and AHCA. Providers are prohibited from filing additional claims for Medicaid deductibles or co-payment reimbursement. Providers must not also file claims for Medicaid reimbursement to the Medicaid

Fiscal Agent for its DSNP Members covered under this DSNP Agreement as identified in the Medicare Managed Care Manual Chapter 16b and applicable laws and regulations.

To the extent Provider provides Services to or for the benefit of DSNP Members, DSNP Members will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]. Without limiting the generality of the foregoing, Provider agrees that in no event, including but not limited to (1) non-payment by Plan of any amounts that are Plan's legal obligation, (2) insolvency of Plan, or (3) Plan's breach of the Agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any DSNP Member or person acting on behalf of the DSNP Member for Services provided pursuant to the DSNP Agreement. [42 C.F.R. §§422.504(g) and (i) and MMCM ch. 11 §§100.3 and 100.4] (4) Provider will not impose cost-sharing requirements on DSNP Members in excess of the amounts allowed under the Florida Medicaid State Plan. [42 CFR 422.504(g)(1)(iii)]

Timely Submission of Claims

The Health Plan abides by CMS guidelines for timely submission of claims. Timely submission is subject to statutory changes. Therefore, claims should be submitted within the timely filing period established by regulatory statute, unless your contract stipulates something different.

Health Plan members cannot be billed for services denied due to a lack of timely filing. Claims appealed for "timely filing" should be submitted with "proof" along with a copy of the EOP and the claim. Acceptable proof of timely filing will be in the form of a registered postal receipt signed by a representative of the health plan or a similar receipt from other commercial delivery services.

Maximum Out-of-Pocket Expenses (MOOP)

The term Maximum Out-of-Pocket (MOOP) refers to the limit on how much a Medicare Advantage health plan enrollee has to pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. Co-payments, co-insurance and deductibles comprise member expenses for purposes of MOOP. MOOP is not applicable to the member's Medicare Part B Premium.

All of our Health Plans have a MOOP. If a member reaches a point where they have paid the MOOP during a calendar year (coverage period), the member will not have to pay any out-of-pocket costs for the remainder of the year for covered Medicare Part A and Part B services to a Participating Network Provider. If a member reaches this level, the Health Plan will no longer deduct any applicable member expenses from the provider's reimbursement. Supplemental benefits, non-Medicare covered services; and all out of network services will not count toward the yearly out of pocket maximum.

The MOOP can vary by Health Plan and may change from year to year. Please refer to the Summary of Benefits available online at our websites:

www.freedomhealth.com / www.youroptimumhealthcare.com.

You may confirm that a member has reached their MOOP by contacting the Member Services Department.

Physician and Provider Reimbursement

Reimbursement for covered services is based on the negotiated rate as established in the Physician or Provider Agreement. Services that require a referral and/or prior authorization will be denied if services were rendered prior to approval. Please refer to your Physician or Provider Agreement to determine the method that applies to your contract. Capitation payments, based upon the number of assigned members, will be made by the 15th day of the month.

Completion of "Paper" Claims

Paper claims should be completed in their entirety, including but not limited to the following elements:

- The Health Plan member's name and their relationship to the subscriber.
- The subscriber's name, address and insurance ID as indicated on the member's identification card.
- The subscriber's employer group name and number (if applicable).
- Information on other insurance or coverage.
- The name, signature, place of service, address, billing address and telephone number of the physician/provider performing the service.
- The tax identification number, NPI number for the physician or provider performing the service.
- The appropriate ICD-10 codes at the highest level.
- The standard CMS procedure or service codes with the appropriate modifiers.
- The number of service units rendered.
- The billed charges.
- The name of the referring physician.
- The dates-of-service.
- The place-of-service; of the "Face to Face" encounter location.
- The referral and/or authorization number.

- The NDC for drug therapy.
- Any job-related, auto-related or other accident-related information, as applicable.

Electronic Claims Submission

Electronic data filing requires billing software through which you can electronically send claims data to a clearinghouse. Since most clearinghouses can exchange data with one another, you can continue to use your existing clearinghouse even when it is not the clearinghouse selected by the Health Plan.

Prior to submitting claims through a clearinghouse exchange, you must check with your existing clearinghouse to make sure they can complete the transaction with the health plan's vendor. If you do not have a clearinghouse or have been unsuccessful in submitting claims to your clearinghouse, please contact your Provider Relations Representative for assistance.

Our trading partner, Change HealthCare, can help establish electronic claims submissions connectivity with our Health Plan. You will need our payer number (distinct for each plan), which is 41212 for Freedom Health (Medicare) and 20133 for Optimum HealthCare.

Tips on successfully submitting electronic claims:

- Ensure your clearinghouse can remit information to our trading partner, Change Healthcare (access.emdeon.com/CIHS).
- Use the billing name and address on the electronic billing format that matches our records.
- Please notify our office of any name and address changes in writing.
- Field NM1 relates to box 33 of a CMS1500 or the UB04 for all electronic claims transmissions and 837's.
- Contact Change Healthcare (access.emdeon.com/CIHS) with any transmission questions at 1-800-845-6592

.
*Currently not available for dual specialty providers, PCP's with IPA affiliations, anesthesiology or ambulance providers.

Electronic Transactions and Code Sets

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). HIPAA includes a series of administrative

simplification provisions including the adoption of national standards for electronic health care transactions.

On October 16, 2003, the Electronic Transaction and Code Set provision of HIPAA went into effect. Law requires payers to have the capability to send and receive all applicable HIPAA-compliant transactions and code sets.

One requirement is that the payer must be able to accept a HIPAA-compliant 837 electronic claim transaction, in standard format, using standard code sets and standard transactions. Specifically, claims submitted electronically must comply with the following provider-focused transactions:

- 270/271 – Health Insurance Eligibility/Benefit Inquiry & Response
- 276/277 – Health Care Claim Status Request & Response
- 278 – Health Care Services Review – Request for Review and Response
- 835 – Health Care Claim Payment/Advice

The X12N-837 claims submission transactions replaces the manual CMS 1500/UB92 forms. All files submitted must be in the ANSI ASC X12N format, version 4010A, as applicable.

Encounter Data

Encounter Data is a record of covered services provided to our members. An Encounter is an interaction between a patient and provider (health plan, rendering physician, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient. The Health Plan requires the submission of claims for all encounters in order for the Health Plan to achieve state and federal reporting requirements.

Providers reimbursed on a capitation basis must file claims for all services. Claims submitted under a capitation contract are referred to as “encounter data”. Encounter data can be submitted on a “paper claim” format or through Electronic Data Interface (EDI) following the same rules as submitting claims. The Health Plan recognizes these services as paid under the capitation contract and not paid to the physician or provider directly. These services become an integral part of the Health Plan’s claims history database and are used for analysis and reporting. Capitated physicians and providers who do not submit encounter data could be terminated from the Health Plan.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is the procedure used to process health care payments for a patient with one or more insurers providing health care benefit coverage. Prior to claims submission, it is

important to identify if any other payer has primary responsibility for payment. If another payer is primary, that payer should be billed prior to billing the Health Plan.

When a balance is due after receipt of payment from the primary payer, a claim should be submitted to the health plan for payment consideration. The claim should include information verifying the payment amount received from the primary payer as well as a copy of their explanation of payment statement. Upon receipt of the claim, the health plan will review its liability using the COB rules and/or the Medicare/Medicaid "crossover" rules—whichever is applicable. Health Plan will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post payment to determine likely cases based on information obtained through communications with members and providers. Health Plan handles the filing of liens and settlement negotiations both internally and externally via its vendors.

Correct Coding

The Health Plan has adopted a policy of reviewing claims to ensure "correct coding". The Health Plan utilizes a corrective coding re-bundling / unbundling software, which is integrated with our claims payment system. Services that should be bundled and paid under a single procedure code will be subject to review.

Claims Appeals

Claims appealed for the denial "other medical reasons" should be submitted to the attention of the Appeals and Grievance Department. Please include documentation explaining why an authorization was not obtained, any pertinent medical records, a copy of the claim(s) and a copy of the denial statement received.

No authorization claims appeal for denial of timely filing, incorrect payment or denied in error, should be submitted to the attention of the Claims Department at the Health Plan's claims address. The timeframe for appealing a claim denial is 60 days from the date of the denial on the explanation of benefits/payment. Cases appealed after the 60-day time limit will be denied for "untimely filing". There is no "second level" consideration for appeals outside the timely filing requirement. Acceptable proof of timely filing will be in the form of a registered postal receipt signed by a representative of the Health Plan, or a similar receipt from other commercial delivery services.

The Health Plan has up to 60 days to review the request for medical necessity and conformity to the Health Plan's guidelines. The Health Plan is not responsible for payment of medical records generated as a result of a claims appeal. Cases received for lack of necessary documentation will be denied.

The physician or provider is responsible for providing the requested documentation within 60 days of the denial in order to re-open the case. Records and documents received after that timeframe will not be reviewed and the case will be closed.

In the case of a review in which the physician or provider has complied with Health Plan guidelines and services are determined to be medically necessary, the denial will be overturned. The physician or provider will be notified in writing to re-file the claim for payment. If the claim was previously submitted and denied, the Health Plan will adjust it for payment after the decision is made to overturn the denial.

Reimbursement for Covering Physicians

Covering physicians for PCPs must agree to abide by Utilization Management and Quality Management guidelines. The payment rate is according to the Physician Agreement between the contracted PCP and the Health Plan – unless other arrangements are in place. In the case of a capitated PCP, the covering physician will seek payment for services from the contracted physician. The covering physician shall not seek payment from the Health Plan or the Health Plan's member with the exception of those services for which the assigned PCP would have been permitted to collect, i.e., co-payments, deductibles, and/or co-insurance from the member.

Fee Schedule Updates

The Health Plan updates fee schedules at the time they are publicly available by Medicare or Medicaid. Most negotiated reimbursement rates are based upon "prevailing" rates of Medicare or Medicaid.

Online Claims Information

The Health Plan encourages physicians and providers to check the status of their claims on the Provider Portal. In addition to checking claims status, you can also verify eligibility and benefit information. You will need your log in ID and password to access this information. Access the Provider Portal on our websites at www.freedomhealth.com and www.youroptimumhealthcare.com > Provider > Provider Portal. To learn more about using our website, please contact your local Provider Relations representative.

9. GRIEVANCE & APPEALS

Introduction

The Health Plan provides for member and provider grievances and appeals in accordance with CMS and Florida State guidelines.

Definitions

Adverse Determination – An adverse determination is a decision regarding admission, care, continued stay or other health care services to deny, reduce, or terminate services. The decision is based on the Health Plan's approved criteria for medical necessity, appropriateness, health care setting, level of care of effectiveness and coverage for the requested service.

Appeal – An appeal is a request to review an adverse initial determination made by the Plan regarding health care services or payment.

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

Grievance & Appeals System

Health Plan members have the right to express verbal or written grievances and appeals, as outlined in Member Rights and Responsibilities. These rights are provided in the Evidence of Coverage Document available to all of our members.

The Health Plan has developed a system to receive, process and resolve member grievances and appeals to support these rights. All grievances and Part C medical appeals are handled by the Health Plan's Grievance and Appeals Department. Part D Drug appeals are handled by the Health Plan's Pharmacy Department. Late Enrollment Penalty (LEP) appeals are handled by the Health Plan's Enrollment Department.

The Health Plan will provide assistance with the grievance and appeals filing process. Providers may also contact Freedom Health or Optimum HealthCare to file or support a members' filing of an appeal or a grievance. Members may also contact the Health Plan to file an appeal or a grievance. Appeals and grievances are filed by mail, telephone, e-inquiry using the member portal or fax at:

Freedom Health Inc.
C/O Grievance and Appeals Coordinator
P.O. Box 152727
Tampa, FL 33684
Phone: 888-796-0947
Fax: 813-506-6235

Optimum HealthCare Inc.
C/O Grievance and Appeals Coordinator
P.O. Box 152727
Tampa, FL 33684
Phone: 866-245-5360
Fax: 813-506-6235

From October 1 to March 31, Member Services staff is available 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, staff is available Monday through Friday, 8 a.m. to 8 p.m. EST to assist with questions regarding grievances and appeals.

Members may be assisted or represented by an outside legal advisor, practitioner, or other designated representative during the appeal or grievance processes. The Health Plan requires written documentation of such representation and advanced notice in the event that the representative needs to attend any scheduled meetings or hearings.

Providers who want to file an appeal or request additional information regarding pre-service denials, grievances, or pre-service denial appeals, may contact Member Services to obtain information on how to file an appeal. Written appeal requests should identify the item(s) or service(s) being appealed and include any additional information to support the request.

The Health Plan's grievance and appeals policies are available upon request to members and providers.

Grievance & Appeals

This section of the provider manual provides guidance to participating providers on the Health Plan's appeal and grievance process. Member appeals and grievances are detailed in the Explanation of Coverage (EOC). The appeal and grievance process for members of a Medicare Advantage plan is the same regardless of the type of plan in which the member is enrolled. Please contact a Provider Relations representative for any additional information needed.

Member Grievance & Appeals

All participating providers or entities delegated for Network Management and Development are to use the same standards as defined in this section. Compliance is monitored on an ongoing basis and formal audits are conducted annually.

Participating Provider Claims Appeals

This section explains the appeal process for denied claims only.

The terms and conditions of payment to participating providers follow the mutual obligations of the Health Plan and providers per our Provider Agreement. Per our Agreement, physicians and providers may not bill our members, except for any co-payments or co-insurance. Any claim disputes for services provided to our members must be resolved per the Agreement's terms and conditions. Balance billing members is also prohibited by Medicare regulations.
Claims may be denied for reasons including, but not limited to:

- Lack of pre-certification
- Services not billed as authorized
- Services denied as not Medical necessary
- Member's exhaustion of benefits
- Items or services not covered either in the Member's Evidence of Coverage or by Medicare

The specific reason for denial of a claim will be provided in the Evidence of Payment document that is sent to providers along with all paid/denied claims.

Once a claim is denied, the provider may request a reconsideration regarding the Health Plan's decision. Providers must make this request in writing within 60 days of receipt of the initial claims denial and send the request to the address provided below. Additional information to support the request may be sent at this stage. For claim denial reasons not listed above, please see the Claims Appeals Section in Chapter 8 of this manual to better understand claim disputes.

Submit written claims appeal for denials related to other medical reasons to:

Freedom Health Inc.
C/O Grievance and Appeals Coordinator
P.O. Box 152727
Tampa, FL 33684
Fax: 813-506-6235

Optimum HealthCare Inc.
C/O Grievance and Appeals Coordinator
P.O. Box 152727
Tampa, FL 33684
Fax: 813-506-6235

Non-Participating Providers Appeal

The Health Plan encourages the use of participating providers, but when a non-participating provider is used, the non-participating provider must follow these steps:

- Contact the Health Plan for all pre-service authorization requests. All claims of non-participating providers for services provided without a proper authorization will be denied.
- Providers and members are notified in writing of approved or denied claims.
- If a claim is denied, the non-participating provider can file an appeal. However, all non-participating providers must sign a Waiver of Liability Form in order for the claim to be reconsidered for payment. The Waiver of Liability Form is attached to the Appeal Rights notice issued to the provider upon claim denial, and with Appeal Acknowledgment Letter and subsequent requests if necessary. If the Waiver Form is not completed and returned by the specified date (within 60 days of receipt of the appeal request), the case will be dismissed per Medicare regulations.
- Upon receipt of the Waiver Form, the claim and reason for the denial are reviewed.
- The Appeals staff either pays the claim or presents the case for administrative review.
- Claims approved for payment on appeal are processed and paid within established timeframes to either the provider or member – whichever is appropriate.
- Claims denied for payment after the appeal review, are processed and forwarded to Maximus Federal Services, the Independent Review Entity (IRE) contracted by CMS.

Pre-Service Appeals

Providers can request reconsiderations on previously denied authorization requests. For standard pre-service reconsiderations, a physician can request the reconsideration on the member's behalf without submitting a representative form. Any other individual requesting reconsideration on a member's behalf must be appointed the member's representative for the appeal process.

Appointment of Representative form: https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms012207. Reconsideration requests must be submitted within 60 days of the authorization denial date. The Health Plan will process a standard pre-service reconsideration within 30 days of the request. The resolution time frame may be extended up to 14 days if requested by the member of it additional documentation is required from a non-contracted provider and is in the interest of the member.

Dual-enrolled (DSNP) members requesting an appeal for benefits covered only under Medicaid, must be submitted in writing. The member may request the appeal verbally with the Plan's Member Services department; however, a written request will also need to be submitted within 10 days of the original verbal request.

Additionally, DSNP members may request that their benefits be continued throughout the appeal process for certain services (covered only by their Medicaid benefit) that were previously approved by the Plan but are now being terminated, suspended or reduced. If the member wants to continue their benefits through the appeals process, they must submit their appeal request before the period covered by the previous authorization expires. If the plan denies the member's appeal, the member may request these benefits be continued up through the Medicaid Fair Hearing process. However, if the request remains denied, the member may be responsible for payment of these services.

If an appeal for a Medicaid-richer benefit is denied by the Health Plan, the member can request a Medicaid Fair Hearing. The request for hearing must be filed within 120 days of the written notice of appeal denial. All instructions and requirements for Medicaid Fair Hearing requests will be provided to the member in the written notice of appeal denial issued by the Health Plan.

Member Claim Appeals

Members, or their representatives on their behalf, may request appeals for denied claims and cost-share applied to claims that they feel is incorrect or an error. Appeal requests must be submitted within 60 days of the claim process (paid/denied) date. The Health Plan will process claim appeals within 60 days of the request for Medicare benefits, and within 30 days of the request for Medicaid-richer benefits for dual-enrolled (DSNP) members. An appeal request received from a provider for their own claim is classified as a provider appeal. An appeal request received from a provider on the member's behalf for a claim/claims from another provider is classified as member appeal and the requesting provider must be appointed as the member's representative for the appeal process via the Appointment of Representative form.

Appointment of Representative form:
https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms012207

Expedited Pre-Service Appeals

Providers can request an expedited appeal for pre-service requests verbally or in writing. Expedited appeals may be requested when the member and/or the provider believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Some reasons to request an expedited appeal are:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The member requests the extension of benefits.

Providers may file an appeal on a member's behalf and/or support a member's appeal without concern of repercussion from the Health Plan.

The Health Plan resolves an expedited appeal within 72 hours after receipt. The resolution timeframe may be extended up to 14 days if requested by the member or if additional documentation is required from a non-contracted provider and is in the interest of the member. The Health Plan may deny the request for an expedited appeal and process it as a standard appeal.

Dual- enrolled DSNP members may request that their benefits be continued throughout the appeal process for certain services (covered only by their Medicaid benefit) that were previously approved by the Plan but are now being terminated, suspended or reduced. If the member wants to continue their benefits through the appeals process, they must submit their appeal request before the period covered by the previous authorization expires. If the plan denies the member's appeal, the member may request these benefits be continued up through the Medicaid Fair Hearing process. However, if the request remains denied, the member may be responsible for payment of these services.

If an appeal for a Medicaid-richer benefit is denied by the Health Plan, the member can request a Medicaid Fair Hearing. The request for hearing must be filed within 120 days of the written notice of appeal denial. All instructions and requirements for Medicaid Fair Hearing requests will be provided to the member in the written notice of appeal denial issued by the Health Plan.

Grievance Process

Providers cannot file a grievance but are able to submit a complaint. Please see the Provider Complaint Process that appears further in this section. Members may file a grievance within 60 days from the event that initiated the grievance. DSNP members who are grieving about an incident related to the Medicaid richer benefit can file a complaint or grievance at any time. The Health Plan will resolve the grievance within 30 days of receipt, but it may extend the resolution period by up to 14 days if requested by the member or if additional documentation is required from a non-contracted provider and is in the interest of the member.

Provider Complaint Process

Initial Complaint

A Provider Relations representative is assigned to each contracted provider to assist in the administration of services to Health Plan members. Any provider who has a complaint may call the Provider Relations Department at 1-888-796-0947 for Freedom Health or 1-866-245-5360 for Optimum HealthCare. A Provider Relations representative will assist the provider to resolve the complaint.

Formal Complaint Procedures

Formal complaints will be handled by the Provider Relations Compliance Team with the cooperation of other departments involved with the complainant's concerns, if the Provider Relations representative is unable to resolve the issue. All issues with medical management will be reviewed confidentially by the Health Plan's Utilization Management Department.

- Providers are given 45 days to file a written complaint for issues that are not about claims.
- Within three (3) business days of receipt of a complaint, the Provider Relations representative will notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution.
- All issues with medical management will be reviewed confidentially by the Health Plan's Utilization Management Department.

A resolution to the provider's complaint will be due within 60 days from the receipt of the formal complaint, except when information is needed from non-participating providers or providers outside of the Health Plan's service area. In such cases, this period may be extended an additional 30 days.

The complainant will receive a written notice when an extension is necessary. The time limitations requiring completion of the grievance process within 60 days will be paused after the Health Plan has notified the complainant in writing that additional information is required to review the complaint properly. Upon receipt of the additional information required, the time for completion of the grievance process will resume. The Health Plan will communicate with the complainant upon completion of the full complaint review process.

The Health Plan will maintain an accurate record of each provider complaint. Each record will include the following:

- Complete description of the complaint.
- Complainant's name and address.
- Complete description of factual findings and conclusions after the completion of the formal complaint process.

- Complete description of the Health Plan's conclusions pertaining to the complaint, as well as the Health Plan's final disposition of the grievance.

To submit documentation in support of the complaint, send all documents via e-mail to ProviderGrievances@freedomh.com or fax to 813-490-5303. You may also submit documentation to the address below.

Provider Grievances
P.O. Box 151257
Tampa, FL 33684

10. FORMS & DOCUMENTS

The following sample forms and documents are included in this manual:

- Case and Disease Management Referral Form
- Health Assessment Tool (HAT) Form
- Member Rights & Responsibilities
- PCP Request for Member Transfer
- Pharmacy Prior Authorization / Step Therapy Form
- Pre – Certification Request Form
- Provider Grievance Form
- Quick Reference Guides
- Referral Form
- Sample Member ID Cards
- Specialty Medication Request Form
- Incident Report Form
- Model Waiver of Liability
- Appointment of Representative
- Cultural Competence for Provider Orientation

Case/Disease Management Referral Form

Please complete all applicable sections of this form, indicating whether the member is being referred for a telephonic assessment by a Nurse, Social Worker, Registered Dietitian or all.

Referral Date: _____ Referred By: _____ Phone: _____
(Provider Name) (Provider Phone Number)

Primary Office Contact for Information: _____

Member Name: _____ ID #: _____

Member DOB: _____ Member Phone #: _____

Reason for Referral:

I. Nursing Case Management Needs

Uncontrolled Diabetes
COPD/Asthma Complications
Transplant
CVD (specify below)
CHF
Wounds (unhealed over 30 days.)
OB
HIV/AIDS
Multiple Events (≥2 hospital admissions in 30 days, multiple ER visits, etc.)
Multiple Comorbidities
Frequent Falls
Other _____

Additional Comments:

II. Dietitian Case Management Needs

Diabetes Nutrition Management
Heart Healthy Diet Education
COPD Diet Education
Weight Management
Healthy Eating Habits
Other _____

Additional Comments:

III. Social Services Case Management Needs

Financial (utilities, etc.)
Food Assistance
Member is in coverage gap
Copay Assistance
Behavioral Health
Transportation Barriers
Other _____

Additional Comments:

Please Fax this form and any supporting documentation to **1-888-314-0794**.
Case Management Department general phone: 1-888-211-9913 ext.11238.

Revised 3/10/2022

FREEDOM HEALTH

PO Box 15804, Tampa, FL 33684-9846

Health & Wellness Material

FRH23HATP1

Health Assessment Tool (HAT)

Please complete this annual survey. This information will help us understand your health needs. Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s). If you have any questions regarding this form, please call 1-800-401-2740. TTY: 711

Please disregard this request if you have recently mailed a completed Health Assessment Tool.

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

A. Physical Health Rating

1. On a usual basis, how do you rate your health? (check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

2. What is your height? (whole numbers) _____ Feet _____Inches 3. What is your weight? (whole numbers) _____lbs.

B. Activities of Daily Living

4. How much help do you need with the following? (check one box for each activity)

Activity	No Help Needed	Some Help Needed	Complete Help Needed
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Eating	❑	❑	❑
Getting out of Bed or Chair	❑	❑	❑
Preparing Meals	❑	❑	❑
Taking your Medicine	❑	❑	❑
Using the Bathroom	❑	❑	❑
Walking	❑	❑	❑
Remembering & Decision Making	❑	❑	❑

5. If you need help, do you have someone close by or a caregiver who helps you? ❑ Yes ❑ No ❑ Hospice ❑ N/A

C. Health History & Treatment

6. When did you last see your Primary Care Physician?
(check one) ❑ Less than 6 months ❑ More than 6 months ❑ 12 months ago or greater
If you have not seen your Primary Care Physician in the last 6 months, please call the office to schedule an appointment.

7. Do you currently use any medical equipment such as oxygen, electric bed or wheelchair in your home? ❑ Yes ❑ No

8. Are you receiving any nursing, therapy or home health care in your home? ❑ Yes ❑ No

9. Do you have blindness or trouble seeing even when wearing glasses? ❑ Yes ❑ No

10. Do you have deafness or trouble hearing even when wearing a hearing aid? ❑ Yes ❑ No

11. Have you received: (check all that apply) ❑ Flu shot in the past year ❑ Pneumonia shot in the past 5 years ❑ Unsure

12. Have you had a Pap test in the past 2 years? ❑ Yes ❑ No ❑ Unsure ❑ N/A

13. Have you had a mammogram in the past 2 years? ❑ Yes ❑ No ❑ Unsure ❑ N/A

14. Have you had a colon cancer check in the last 10 years? ❑ Yes ❑ No ❑ Unsure

15. Please check whether you have any of the following: (CHECK ALL THAT APPLY)

❑	Asthma	❑	HIV/AIDS
❑	Cancer	❑	Kidney Problems
❑	Congestive Heart Failure	❑	Depression or Other Mental Health Issues
❑	COPD or Emphysema or Chronic Bronchitis	❑	Organ Transplant
❑	Frequent Falls	❑	Diabetes
❑	Heart Attack or blocked arteries	❑	Skin Ulcer/Nonhealing Wound
❑	High Blood Pressure	❑	Other _____

16. If you are concerned about your health, do you know what steps you can take to improve your health? (check one)
❑ I am not concerned about my health. ❑ I am concerned and know steps that I can take.
❑ I am concerned, and my doctor is working with me. ❑ I am concerned and I would like information on steps to improve my health.

17. Is there anything preventing you from taking steps to improve your health? (check one)
❑ No ❑ Yes, and I would like a call to discuss. ❑ Yes, and I am working on it.

D. Lifestyle & Well-being

18. Do you use tobacco? (smoke, chew, snuff, vape or in any other form) ❑ Yes ❑ No ❑ Want to quit

19. Does drinking alcohol interfere with your personal or work life? ❑ Yes ❑ No ❑ N/A, I Don't Drink

20. Do you feel you get enough physical activity/exercise? ❑ Yes ❑ No ❑ Want to improve

21. Do you feel that your diet supports a healthy lifestyle? ❑ Yes ❑ No ❑ Want to improve

22. Do personal or family health issues result in loss of work/daily activities? ❑ Yes ❑ No ❑ Unsure

23. What is your living situation today? (check one)
❑ I have a steady place to live.
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

24. Do you feel safe where you live? (check one) ❑ Yes ❑ No

25. Within the past 12 months, you worried that your food would run out before you got money to buy more? (check one)
❑ Often true ❑ Sometimes true ❑ Never true

26. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? ❑ Yes ❑ No

27. Over the past 2 weeks, how often have you been bothered by any of the following feelings?
A. Feeling down, depressed or hopeless ❑ Not at All ❑ Several Days ❑ More than Half the Days ❑ Nearly Every Day
B. Little interest or pleasure in doing things ❑ Not at All ❑ Several Days ❑ More than Half the Days ❑ Nearly Every Day

28. Are you experiencing any of the following common effects or feelings of stress?
(Check all that apply): ❑ Anxiety ❑ Drug/Alcohol Abuse ❑ Irritability/Anger ❑ Sadness /Depression ❑ Social Withdrawal
❑ Chest Pain ❑ Headache ❑ Muscle tension/Pain ❑ Sleep Problem ❑ Upset Stomach
If you have any of the above symptoms or feel that you are depressed, please set up an appointment with your PCP.

29. Would you like information on how you can get help for these feelings? ❑ Yes ❑ No

30. Would you like information on Health Care Advance Directives such as a Living Will? ❑ Yes ❑ No

E. Demographics

31. Do you identify with a particular cultural or spiritual group? ❑ Yes, _____ ❑ No ❑ Do not wish to answer

32. What is your preferred language? ❑ English ❑ Spanish ❑ French Creole ❑ Other: _____

33. What is your ethnicity? ❑ Hispanic ❑ Non-Hispanic ❑ Other: _____ ❑ Decline to Answer

34. What race do you belong to? ❑ African American ❑ Alaskan Native ❑ American Indian ❑ Asian ❑ Caucasian
❑ Pacific Islander or Native Hawaiian ❑ Other: _____ ❑ Decline to Answer

OPTIMUM HealthCare, Inc.

PO Box 15804, Tampa, FL 33684-9846

Health & Wellness Material

OPT23HATP1

Health Assessment Tool (HAT)

Please complete this survey. This information will help us understand your health needs. Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s). If you have any questions regarding this form, please call 1-866-245-5360. TTY: 711.

Please disregard this request if you have recently mailed a completed Health Assessment Tool.

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

A. Physical Health Rating

1. On a usual basis, how do you rate your health? (check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

2. What is your height? (whole numbers) _____ Feet _____Inches 3. What is your weight? (whole numbers) _____lbs.

B. Activities of Daily Living

4. How much help do you need with the following? (check one box for each activity)

Activity	No Help Needed	Some Help Needed	Complete Help Needed
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Eating	❑	❑	❑
Getting out of Bed or Chair	❑	❑	❑
Preparing Meals	❑	❑	❑
Taking your Medicine	❑	❑	❑
Using the Bathroom	❑	❑	❑
Walking	❑	❑	❑
Remembering & Decision Making	❑	❑	❑

5. If you need help, do you have someone close by or a caregiver who helps you? ❑ Yes ❑ No ❑ Hospice ❑ N/A

C. Health History & Treatment

6. When did you last see your Primary Care Physician?
(check one) ❑ Less than 6 months ❑ More than 6 months ❑ 12 months ago or greater
If you have not seen your Primary Care Physician in the last 6 months, please call the office to schedule an appointment.

7. Do you currently use any medical equipment such as oxygen, electric bed or wheelchair in your home? ❑ Yes ❑ No

8. Are you receiving any nursing, therapy or home health care in your home? ❑ Yes ❑ No

9. Do you have blindness or trouble seeing even when wearing glasses? ❑ Yes ❑ No

10. Do you have deafness or trouble hearing even when wearing a hearing aid? ❑ Yes ❑ No

11. Have you received: (check all that apply) ❑ Flu shot in the past year ❑ Pneumonia shot in the past 5 years ❑ Unsure

12. Have you had a Pap test in the past 2 years? ❑ Yes ❑ No ❑ Unsure ❑ N/A

13. Have you had a mammogram in the past 2 years? ❑ Yes ❑ No ❑ Unsure ❑ N/A

14. Have you had a colon cancer check in the last 10 years? ❑ Yes ❑ No ❑ Unsure

15. Please check whether you have any of the following: (CHECK ALL THAT APPLY)

❑	Asthma	❑	HIV/AIDS
❑	Cancer	❑	Kidney Problems
❑	Congestive Heart Failure	❑	Depression or Other Mental Health Issues
❑	COPD or Emphysema or Chronic Bronchitis	❑	Organ Transplant
❑	Frequent Falls	❑	Diabetes
❑	Heart Attack or blocked arteries	❑	Skin Ulcer/Nonhealing Wound
❑	High Blood Pressure	❑	Other _____

16. If you are concerned about your health, do you know what steps you can take to improve your health? (check one)
❑ I am not concerned about my health. ❑ I am concerned and know steps that I can take.
❑ I am concerned, and my doctor is working with me. ❑ I am concerned and I would like information on steps to improve my health.

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20. Do you feel you get enough physical activity/exercise? ❑ Yes ❑ No ❑ Want to improve

21. Do you feel that your diet supports a healthy lifestyle? ❑ Yes ❑ No ❑ Want to improve

22. Do personal or family health issues result in loss of work/daily activities? ❑ Yes ❑ No ❑ Unsure

23. What is your living situation today? (check one)
❑ I have a steady place to live.
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

24. Do you feel safe where you live? (check one) ❑ Yes ❑ No

25. Within the past 12 months, you worried that your food would run out before you got money to buy more? (check one)
❑ Often true ❑ Sometimes true ❑ Never true

26. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? ❑ Yes ❑ No

27. Over the past 2 weeks, how often have you been bothered by any of the following feelings?
A. Feeling down, depressed or hopeless ❑ Not at All ❑ Several Days ❑ More than Half the Days ❑ Nearly Every Day
B. Little interest or pleasure in doing things ❑ Not at All ❑ Several Days ❑ More than Half the Days ❑ Nearly Every Day

28. Are you experiencing any of the following common effects or feelings of stress?
(Check all that apply): ❑ Anxiety ❑ Drug/Alcohol Abuse ❑ Irritability/Anger ❑ Sadness /Depression ❑ Social Withdrawal
❑ Chest Pain ❑ Headache ❑ Muscle tension/Pain ❑ Sleep Problem ❑ Upset Stomach
If you have any of the above symptoms or feel that you are depressed, please set up an appointment with your PCP.

29. Would you like information on how you can get help for these feelings? ❑ Yes ❑ No

30. Would you like information on Health Care Advance Directives such as a Living Will? ❑ Yes ❑ No

E. Demographics

31. Do you identify with a particular cultural or spiritual group? ❑ Yes, _____ ❑ No ❑ Do not wish to answer

32. What is your preferred language? ❑ English ❑ Spanish ❑ French Creole ❑ Other: _____

33. What is your ethnicity? ❑ Hispanic ❑ Non-Hispanic ❑ Other: _____ ❑ Decline to Answer

34. What race do you belong to? ❑ African American ❑ Alaskan Native ❑ American Indian ❑ Asian ❑ Caucasian
❑ Pacific Islander or Native Hawaiian ❑ Other: _____ ❑ Decline to Answer

Member Rights and Responsibilities

The Plan strongly endorses the rights of members as supported by State and Federal laws. As well, the Plan expects members to be responsible for certain aspects of the care and treatment they are offered and receive. All member rights and responsibilities are to be acknowledged and honored by the Plan's staff and all contract providers. Contract providers are provided with a declaration of the Plan's member rights and responsibilities in their Provider Manual and on the Plan's website. In addition, providers are given a handout of these rights and responsibilities and urged to post them in their respective offices. Members are afforded a listing of their rights and responsibilities as a member of the Plan in their Evidence of Coverage.

MEMBER RIGHTS

As a member of the Plan, you have the right to:

- Be treated with courtesy and respect, with appreciation of your dignity, and protection of your need for privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for your care.
- Know what patient support services you can get, and if an interpreter is available if you do not speak English.
- Know what rules and laws apply to the conduct of the staff of the Plan and contracted providers.
- Be provided by the Plan's providers, information about diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Accept or refuse any treatment, except as provided by law, and complete an advance directive.
- File a complaint with the state survey and certification agency for any dissatisfaction with the Plan's process for handling advance directives.
- If eligible for Medicare, know upon request and in advance of treatment, if the health care provider or health care facility accepts the Medicare assignment rate.

- Receive, before treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a reasonable, clear, and understandable detailed bill and, upon request, to have the charges explained.
- Access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- Treatment for any emergency medical condition that will get worse from failure to provide treatment.
- Know if medical treatment is for experimental research and to grant consent or refusal to take part in such experimental research.
- Private handling of medical records and, except when required by law, be given the chance to approve or refuse their release.
- Voice complaints or appeals about the organization or the care it provides.
- Express grievances about any violation of your rights, through the Plan's grievance and appeals system, and to appeal to a state grievance and appeal oversight entity; and for Medicare members, through the CMS established appeal process.
- Participate with practitioners in making decisions about your health care, and provide input into your proposed treatment plan.
- Receive information about the Plan, its services, practitioners and providers, and members' rights and responsibilities.
- Have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the Plan's member rights and responsibilities policies.
- Review, copy, and amend incorrect data in your medical records. You may be denied access to your medical records if a provider believes it could engager your or someone else's physical safety, for some psychotherapy notes, for information compiled for a lawsuit, or for certain other limited circumstances. If you are denied your medical records, you may appeal this decision.
- Receive an accounting of all disclosures of your personal information to third parties.
- Receive a written summary or explanation of your health condition.

MEMBER RESPONSIBILITIES

As a member of the Plan, your provider expects you to:

- Provide your health care provider, to the best of your knowledge, correct and complete information about present complaints, past illnesses, hospital stays, medicines and other health matters.
- Report unexpected changes in your condition to your health care provider.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Discuss with your health care provider if you do not comprehend a course of treatment or what is expected of you.
- Follow the treatment plan suggested by your health care provider and agreed upon by you.
- Keep appointments, and when you are unable to do so for any reason, notify your health care provider or health care facility.
- Answer for your actions if you refuse treatment or do not follow the health care provider's instructions.
- Assure that the financial obligations of your health care are fulfilled as promptly as possible.
- Follow health care facility rules and laws that affect patient care and conduct.

PCP REQUEST FOR MEMBER TRANSFER

Physician:	Member:
ID#:	ID#:
Telephone:	Telephone:
Fax:	Medicare ☐

Summary of Process Review:
PCP may request reassignment only if member's behavior is disruptive to the extent that their continued assignment to the PCP substantially impairs the PCP's ability to provide services to that particular member or other members of the practice. Before request PCP must make serious effort to resolve the behavior issue.

PCP may not request a member transfer because the member exercises his/her option to make treatment decisions with which the PCP disagrees, including the option of no treatment and/or diagnostic testing, lack of compliance with treatment regimen or inability to have the member come to the office.

Documentation required by the Plan:

- Explanation of disruptive behavior and how it has impacted the PCP's ability to provide service to this member or other patients in the PCP's practice.
- PCP's serious efforts to provide reasonable accommodation.
- Medical records or progress notes related to the disruptive behavior and updated diagnosis list.

Please include detailed reason for request:
Disruptive behavior:
Other:
Description:

Please submit a copy of progress notes from the member's medical records that documents your concern.

Physician Signature:	Date:

Please complete this request in its entirely and attach all supporting documentation, including pertinent medical records and office notes. Do not discuss your request to transfer a member from your care until you receive approval.

Submit your request to:
Freedom Health, Inc/Optimum Healthcare, Inc.
5411 Sky Center Dr. 8th Floor, Suite 800 Tampa, FL 33607
-or-
You may fax the completed form and documentation to (888)736-1123.
NOTE-This request may take up to 45 days to process.

Section to be completed by The Health Plan:

Date Received:	Date Closed:	New PCP Assignment: Yes or No Effective date:

FREEDOM HEALTH PLAN
MEDICATION THERAPY REVIEW

INSTRUCTIONS:

- **PLEASE FAX THE COMPLETED PRIOR AUTHORIZATION/STEP THERAPY REQUEST TO THE PHARMACY DEPARTMENT VIA FAX number: (1-844-430-1704)**
- **NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO FREEDOM HEALTH PLAN. FOR AN EXPEDITED REQUEST CALL BY PHONE: (1-833-272-9772)**

PATIENT INFORMATION

LAST NAME: **FIRST NAME:** **MI:**

PATIENT ID NUMBER:

DATE OF BIRTH:

PHARMACY: **PHARMACY PHONE:**

DRUG REQUESTED

NAME: **STRENGTH:** **QUANTITY:** **DURATION OF THERAPY:**

1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG? ☐ **YES** ☐ **NO IF YES, HOW LONG?** _____

START DATE: _____

2. HAS PATIENT HAD A DOCUMENTED ALLERGY/INTOLERANCE TO SIMILAR FORMULARY MEDICATIONS?

☐ **YES** ☐ **NO** ☐ **N/A**

3. LIST THERAPY FAILURE ON ONE OR MORE FORMULARY DRUGS WITHIN THE SAME THERAPEUTIC CLASS:

4. PATIENT DIAGNOSIS:

Please include all relevant documentation, including the most recent tests, procedures, prior therapies tried and failed, etc., to support your request for this drug.

It is important that the following information is filled in completely in order to successfully process your request.

PHYSICIAN NAME: **PHYSICIAN PHONE #**

FIRST: **LAST:**

NPI: **SPECIALTY:** **DATE:**

ADDRESS:

PHYSICIAN FAX: # (FOR FAXED NOTIFICATION): **CONTACT:**

OPTIMUM HEALTHCARE
MEDICATION THERAPY REVIEW

INSTRUCTIONS:

- **PLEASE FAX THE COMPLETED PRIOR AUTHORIZATION/STEP THERAPY REQUEST TO THE PHARMACY DEPARTMENT VIA FAX number: (1-844-430-1704)**
- **NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO OPTIMUM HEALTHCARE. FOR AN EXPEDITED REQUEST CALL BY PHONE: (1-833-272-9773)**

PATIENT INFORMATION

LAST NAME: **FIRST NAME:** **MI:**

PATIENT ID NUMBER:

DATE OF BIRTH:

PHARMACY: **PHARMACY PHONE:**

DRUG REQUESTED

NAME: **STRENGTH:** **QUANTITY:** **DURATION OF THERAPY:**

1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG? ☐ **YES** ☐ **NO IF YES, HOW LONG?** _____

START DATE: _____

2. HAS PATIENT HAD A DOCUMENTED ALLERGY/INTOLERANCE TO SIMILAR FORMULARY MEDICATIONS?

☐ **YES** ☐ **NO** ☐ **N/A**

3. LIST THERAPY FAILURE ON ONE OR MORE FORMULARY DRUGS WITHIN THE SAME THERAPEUTIC CLASS:

4. PATIENT DIAGNOSIS:

Please include all relevant documentation, including the most recent tests, procedures, prior therapies tried and failed, etc., to support your request for this drug.

It is important that the following information is filled in completely in order to successfully process your request.

PHYSICIAN NAME: **PHYSICIAN PHONE #**

FIRST: **LAST:**

NPI: **SPECIALTY:** **DATE:**

ADDRESS:

PHYSICIAN FAX: # (FOR FAXED NOTIFICATION): **CONTACT:**

PRE-CERTIFICATION REQUEST FORM

All REQUIRE MEDICAL RECORDS TO BE ATTACHED

Phone: 888-796-0947 Fax: 866-608-9860 or 888-202-1940

Instructions:

This form is for pre-certification requests which will be processed as quickly as possible depending on the member's health condition.
Do not write STAT, ASAP, Immediate, etc. on this form. Please complete appropriate sections below.

Complete this section for expedited requests ONLY. Medicare's definition of expedited is defined as one where "applying the standard time for making a determination could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function."

If your PHYSICIAN feels the member meets the definition of expedited above, have your physician document his/her reason below:

_____

Complete remainder of form for ALL requests.

Member Information

Name:_____ Date of Birth: _____ Plan ID#:_____

Requesting Provider Information

Date of Request:_____ County: _____

Attestation required: Are you the member's PCP or an agent of the PCP? Yes ___ No ____ Signature _____

Note: Requests should be submitted through the PCP; requests not from the PCP will be reviewed with the PCP.

Requesting provider name:_____ TIN#: _____

Phone: (____)_____ Fax: (____)_____ Contact Person:_____ Ext._____

Please provide a short clinical statement to support your request (or reason for disagreement):

_____

_____

Facility Requested (No Abbreviations)	**Provider Requested** (No Abbreviations)
Name:_____	Name:_____
TIN#: _____ ☐ Non-Par	TIN#: _____ ☐ Non-Par
Phone: (_____)_____ Fax: (_____)_____	Phone: (_____)_____ Fax: (_____)_____

Diagnosis:	**ICD-10 Code**(s)**:**
Diagnosis:	**ICD-10 Code**(s)**:**

Service Requested: Check appropriate request(s)

- □ Abortions
- □ Acute Rehabilitation Facility
- □ ASC for Blepharoplasty, Podiatric Surgery, Reduction Mammoplasty, Rhinoplasty, Septoplasty, Vein treatments, Ocular Surgery, Pain Management Injections, Plastic Surgery only
- □ Chemotherapy
- □ Clinical Trials Not Approved by Medicare
- □ Cosmetic Procedures
- □ Diabetic Education
- □ DME > $500 (see * below)
- □ Enteral Feedings
- □ Experimental/Investigational Procedure
- □ Genetic Testing
- □ Home Health Services
- □ Hospice **** Notification only**
- □ Hyperbaric Oxygen Therapy
- □ Implantable pump/device or stimulator
- □ Injectables/Infusion Therapy
- □ Inpatient Hospital
- □ Medical Nutrition Education
- □ MOHS Procedure (Dermatology)
- □ Non-Participating Provider
- □ Obstetrical Care
- □ Orthotics/Prosthetics > than $500
- □ Outpatient Hospital
- □ Pain Management
- □ Radiation Therapy
- □ Radiology: PET, Pill or Virtual Endoscopy
- □ Rehab Cardiac/Pulmonary/Respiratory
- □ Rehab – any outpatient hospital and any office therapy > than 10 visits.
- □ Skilled Nursing Facility
- □ Sterilizations
- □ TMJ Joint treatment
- □ Transplant
- □ Wound Care (outpatient hospital only)

CPT or HCPC Code(s)	**Description**	**# of Visits/Injections**

*DME > $500 if purchased or > $38.50 per month if rented. Includes all wheelchairs, hospital beds, CPAPs, BiPAPs, nerve and bone growth stimulation devices and oxygen, as well as TENS devices, wound care/wound vacuums and related supplies, repairs, miscellaneous codes and all Medicare non-covered items.

Do Not Use this Form to submit an Appeal

Provider Grievance Form

Request Date: _____

Provider Information:

Name: _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Member Information: (list separately)

Name: _____

ID#: _____

Date of Birth: _____

Service Provided Information:

Date(s) of Service: _____

Place of Service: _____

Please check a complaint reason(s).

____Administration
____Health Care Delivery
____Provider Reimbursement
____Contracting
____Other

Explanation of Issue(s):

Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the complaint to ProviderGrievances@freedomh.com or via fax to (813) 490-5303. You may also submit documentation via mail to: Provider Grievances P.O. Box 151257 Tampa, FL 33684. Your request will be processed once all necessary documentation is received and you will be notified of the outcome.

Failure to submit supporting documentation may delay our response to your complaint.

Freedom Health
Medicare Quick Reference Guide

PROVIDER RELATIONS

Toll-free Telephone	*(800) 401-2740*	**Fax Number**	*(813) 506-6236*
TTY/TDD	*711*	**Secondary Fax Number**	*(888) 313-0332*
Physical Address	5411 Sky Center Dr. 8th Floor Tampa, FL 33607	**Mailing Address**	*P.O. Box 151257* *Tampa, FL 33684*

Website: www.freedomhealth.com **MRA/HEDIS® Portal: https://apps.freedomhealth.com**

Provider Portal Features

- *24-hour access to eligibility and claim status*
- *For Portal help contact Provider Relations at (813) 506-6127*
- *Technical assistance is available by phone at (813) 506-6030*

UTILIZATION MANAGEMENT - AUTHORIZATIONS

UM Department Availability	**Weekdays**	*8:00 a.m. - 5:00 p.m.*	*All Staff*
	Weekends and Holidays	*24 hours a day*	*Select Clinical Staff Only*

Standard Requests	*The health plan's average time to completion is two days, if all information is complete. Please submit requests through the provider portal for the quickest response. Alternatively, requests can be faxed to (866) 608-9860 or (888) 202-1940.*
Expedited Requests	*A request can only be expedited if it is felt that waiting up to the standard time for a decision would place the patient's life, health or ability to regain maximum function in serious jeopardy. Expedited request may be submitted by provider portal, by phone at (888) 796-0947 or by fax to (866) 608-9860 or (888) 202-1940.*

PLACE OF SERVICE CODES

11 - Office	22 - Outpatient Hospital	32 - Nursing Facility	65 - ESRD
12 - Patient's Home	23 - Emergency Room	50 - FQHC	71 - Public Health Clinic
20 - Urgent Care Facility	24 - Ambulatory Surgery Center	61 - Inpatient Rehab	72 - Rural Health Clinic
21 - Inpatient Hospital	31 - Skilled Nursing Facility	62 - Outpatient Rehab	81 - Laboratory

PHARMACY SERVICES

Pharmacy Technical Help	(833) 377-4267
Health Plan Pharmacy	(833) 272-9772
CarelonRX (mail-order)	(833) 203-1735
CarelonRX Fax	(800) 378-0323
CarelonRX Online:	www.carelonrx.com

Web-based Information: *www.freedomhealth.com*

Authorization Required

- *Drugs not listed on the Formulary*
- *Formulary drugs require a Coverage Determination*
- *Duplication of drug therapy*
- *Doses that exceeds the FDA quantity maximum*
- *Most self-injectable and infusion drugs*
- *Brand name requests when a generic is on the Formulary*
- *Formulary and forms*
- *Drug with a step edit and the first line therapy is inappropriate*
- *Prescriptions that exceed $1,000/prescription (some exceptions apply) and/or plan limitations*

NOTE: *This guide is not designed to be an all-inclusive list of covered services under Freedom Health, Inc. It provides current referral and prior authorization instructions. Authorization does not guarantee payment of claims. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable health plan coverage guidelines.* *Updated 01/09/24*

Freedom Health
Medicare Quick Reference Guide

CLAIMS

EDI Clearinghouse	*EMDEON* *Payor ID: 41212*	**Paper Claims**	*Freedom Health, Inc.* *Claims Department* *P.O. Box 151348* *Tampa, FL 33684*

When filing claims that require additional information (i.e. medical records, CLIA updates, EOPs, invoices) please mail supporting documentation to the address listed above.

Claim Disputes - *Please submit all documentation to the address above for claim denials regarding untimely submission, lack of prior authorization, incidental procedures, bundling, unbundling, unlisted procedure codes, non-covered codes, etc., within 90 days of date of denial on EOP.*

COMPLAINTS, APPEALS & GRIEVANCES

Provider complaints on administrative issues related to the health plan's policies, procedures or its authorization/referral processes must be submitted within 45 calendar days from the date of occurrence. A provider may file an appeal or grievance on behalf of the member with the member's written consent. A provider may also seek an appeal through the Appeals Department within 60 calendar days of a claim denial for a service that exceeds authorization, insufficient supporting documentation or late notification. Submit a complaint, an appeal or a grievance, with supporting clinical documentation to the Appeals & Grievances Department fax number or address listed below.

Fax: (813) 506-6235
Freedom Health, Inc.
Appeals & Grievances
P.O. BOX 152727, Tampa, FL 33684

CONTRACTED NETWORKS

Behavioral Health	Carelon Behavioral Health	(888) 273-3710
Chiropractic	*Chiro Alliance*	(716) 712-2830
Dental	*Liberty Dental*	(866) 609-0422
Diabetic Supplies - OTC	*Freedom Member Services*	(800) 401-2740
DME & Home Health	*Freedom Member Services*	(800) 401-2740
Gym	*SilverSneakers®*	(855) 585-2392
Hearing	*Hear USA/HearX*	(800) 333-3389
Laboratory	*LabCorp (Clinical)Provider Service and Live Scheduling* *LabCorp (Clinical) Automated Appointment Scheduling*	(800) 877-5227 (855) 277-8669
Anatomic Pathology	*FreePath/Mark & Kambour (biopsies, excisions)* *AmeriPath Florida/Dermapath Diagnostics (pathology)* *Bostwick Laboratories, Inc. (pathology)* *GI Pathology (pathology)* *Mid-Florida (pathology)* *Miraca Life Sciences (pathology)* *Independent Clinical Laboratories Inc.*	(786) 268-6050 (800) 395-7284 (407) 888-9934 (888) 244-7284 (352) 460-0292 (866) 588-3280 (813) 932-0374
Podiatry	*Freedom Member Services*	(800) 401-2740
Optometry	*Freedom Member Services*	(800) 401-2740

Sign Language Interpreter: Culturalink
Email: Request@theculturalink.com
Phone: (888) 695-1001 Option 1

Language Interpreter: Cyracom
Phone: (833) 723-0109

NOTE: *This guide is not designed to be an all-inclusive list of covered services under Freedom Health, Inc. It provides current referral and prior authorization instructions. Authorization does not guarantee payment of claims. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable health plan coverage guidelines.* *Updated 01/09/24*

Optimum HealthCare
Medicare Quick Reference Guide

PROVIDER RELATIONS

Toll-free Telephone	*(866) 245-5360*	**Fax Number**	*(813) 506-6236*
TTY/TDD	*711*	**Secondary Fax Number**	*(888) 313-0332*
Physical Address	5411 Sky Center Dr. 8th Floor Tampa, FL 33607	**Mailing Address**	*P.O. Box 151257* *Tampa, FL 33684*

Website: www. youroptimumhealthcare MRA/HEDIS® Portal: https://apps.youroptimumhealthcare.com

Provider Portal Features

- *24-hour access to eligibility and claim status*
- *For Portal help contact Provider Relations at (813) 506-6127*
- *Technical assistance is available by phone at (813) 506-6030*

UTILIZATION MANAGEMENT - AUTHORIZATIONS

UM Department Availability	**Weekdays**	*8:00 a.m. - 5:00 p.m.*	*All Staff*
	Weekends and Holidays	*24 hours a day*	*Select Clinical Staff Only*

Standard Requests	*The health plan's average time to completion is two days, if all information is complete. Please submit requests through the provider portal for the quickest response. Alternatively, requests can be faxed to (866) 608-9860 or (888) 202-1940.*
Expedited Requests	*A request can only be expedited if it is felt that waiting up to the standard time for a decision would place the patient's life, health or ability to regain maximum function in serious jeopardy. Expedited request may be submitted by provider portal, by phone at (888) 796-0947 or by fax to (866) 608-9860 or (888) 202-1940.*

PLACE OF SERVICE CODES

11 - Office	22 - Outpatient Hospital	32 - Nursing Facility	65 - ESRD
12 - Patient's Home	23 - Emergency Room	50 - FQHC	71 - Public Health Clinic
20 - Urgent Care Facility	24 - Ambulatory Surgery Center	61 - Inpatient Rehab	72 - Rural Health Clinic
21 - Inpatient Hospital	31 - Skilled Nursing Facility	62 - Outpatient Rehab	81 - Laboratory

PHARMACY SERVICES

Pharmacy Technical Help	(833) 377-4267
Health Plan Pharmacy	(833) 272-9772
CarelonRX (mail-order)	(833) 203-1735
CarelonRX Fax	(800) 378-0323
CarelonRX Online:	www.carelonrx.com
Web-based Information:	www.youroptimumhealthcare.com

Authorization Required

- *Drugs not listed on the Formulary*
- *Formulary drugs require a Coverage Determination*
- *Duplication of drug therapy*
- *Doses that exceeds the FDA quantity maximum*
- *Most self-injectable and infusion drugs*
- *Brand name requests when a generic is on the Formulary*
- *Formulary and forms*
- *Drug with a step edit and the first line therapy is inappropriate*
- *Prescriptions that exceed $1,000/prescription (some exceptions apply) and/or plan limitations*

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Optimum HealthCare Medicare Quick Reference Guide

CLAIMS

EDI Clearinghouse	*EMDEON* *Payor ID: 20133*	**Paper Claims**	*Optimum HealthCare, Inc.* *Claims Department* *P.O. Box 151258* *Tampa, FL 33684*

When filing claims that require additional information (i.e. medical records, CLIA updates, EOPs, invoices) please mail supporting documentation to the address listed above.

Claim Disputes - *Please submit all documentation to the address above for claim denials regarding untimely submission, lack of prior authorization, incidental procedures, bundling, unbundling, unlisted procedure codes, non-covered codes, etc., within 90 days of date of denial on EOP.*

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Fax: (813) 506-6235
Optimum HealthCare, Inc.
Appeals & Grievances
P.O. BOX 152727, Tampa, FL 33684

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DME & Home Health	*Optimum Member Services*	(866) 245-5360
Gym	*SilverSneakers®*	(855) 585-2392
Hearing	*Hear USA/HearX*	(800) 333-3389
Laboratory	*LabCorp (Clinical)Provider Service and Live Scheduling* *LabCorp (Clinical) Automated Appointment Scheduling*	(800) 877-5227 (855) 277-8669
Anatomic Pathology	*FreePath/Mark & Kambour (biopsies, excisions)* *AmeriPath Florida/Dermapath Diagnostics (pathology)* *Bostwick Laboratories, Inc. (pathology)* *GI Pathology (pathology)* *Mid-Florida (pathology)* *Miraca Life Sciences (pathology)* *Independent Clinical Laboratories Inc.*	(786) 268-6050 (800) 395-7284 (407) 888-9934 (888) 244-7284 (352) 460-0292 (866) 588-3280 (813) 932-0374
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FREEDOM HEALTH

OPTIMUM HealthCare, Inc.

REFERRAL FORM

Fax to: (888) 314-0796

Date:_____ Referral Begin Date:_____ End Date:_____ (Dates left blank will default to 90 days)

Member Information

Name:_____

Date of Birth:_____ ID#:_____

Phone: (_____)_____

Referring Physician Information

Name: _____

Phone: (_____)_____ Fax: (_____)_____

Contact Person:_____ Ext._____

Referred To

(Check one) ☐ Physician ☐ Radiology Center ☐ P&O < $500 ☐ Therapy (Must be a par provider) ☐ DME < $500

Name:_____

Address:_____

_____

Phone: (_____)_____ Fax: (_____)_____

Tax ID#:_____

ICD-10:_____ Description:_____

☐ Office Visit x _____ visit(s) ☐ Office Visit and treatment x ____ visit(s)

☐ Office Visit and Treatment x _____ visits with listed services ☐ PT ☐ OT ☐ ST x ____ visit(s)

Code:_____ Description:_____

Code:_____ Description:_____

Code:_____ Description:_____

Code:_____ Description:_____

Facility

Ambulatory Surgery Center only (Inpatient and Outpatient Hospital require Pre-Certification)

Name of Facility:_____ (Must be par provider)

Address:_____

_____

Phone: (_____)_____ Fax: (_____)_____

Tax ID#: _____

COMMENTS OR ADDITIONAL CODES:

Note to receiving Provider/Facility: This referral form is only for services listed above. If you are a non-participating provider, Inpatient Facility or Outpatient Hospital provider an authorization is required for your services. This is not an authorization form and payment is therefore not guaranteed. If you have any questions please call Utilization Management at (888) 796-0947.

Instructions: (This form is for referral to the following only)

- **Participating specialists** for office visit and treatments in the office that do not require pre-certification.
- **Free-standing** (not hospital-based) radiology centers for radiology procedures, except for exclusions (see Pre-Certification List). Simple x-rays, ultrasounds and CT scans can be performed with just a prescription.
- **Ambulatory Surgery Centers** - except for excluded procedures (See Pre-Certification List).
- **Orthotics/Prosthetics** - only orthotic/prosthetic with a purchase price less than $500.00.
- **Physical, Occupational or Speech Therapy**: In free-standing office for Evaluation plus 9 visits (10 total) – home therapy or outpatient therapy and visits more than 10 require Pre-Certification.
- **DME -** only DME with a purchase price less than $500.00 or monthly rental price less than $38.50 per month. Excludes: all wheelchairs, hospital beds, CPAPs, BiPAPs, nerve and bone growth stimulation devices and oxygen, as well as TENS devices, wound care/wound vacuums and related supplies, repairs, miscellaneous codes and all Medicare non-covered items.

One copy to patient's chart and one copy to the Provider and one copy faxed to Plan

H5594_MAPD_ID_CARD_2024

OPTIMUM HealthCare, Inc.

RxBIN#: <XXXXXX> RxPCN#: <XXX>
RxGrp#: <XXXXXXXX> Issuer#: <XXX>
RxID#: <Insert member ID#>

<INSERT PLAN NAME>

ID: <0000000000>
<FIRST><MI><LAST>

MedicareRx
Prescription Drug Coverage

Eff. Date: <xx/xx/xxxx>
PCP: <FIRST><LAST>
Phone: <xxx-xxx-xxxx>

H5594 - PBP - <xxx>

PCP Office Visit: <$> **Urgent Care:** <$>
Specialty Office Visit: <$> **ER:** <$>

Member Services: <X-XXX-XXX-XXXX>
TTY/TDD: <X-XXX-XXX-XXXX> www.youroptimumhealthcare.com

Provider Services (UM): <X-XXX-XXX-XXXX>
24/7 Nurse Advice Line: <X-XXX-XXX-XXXX>
Pharmacy Member Services: <X-XXX-XXX-XXXX>
Pharmacy Technical Support: <X-XXX-XXX-XXXX>
Behavioral Health *(Carelon)*: <X-XXX-XXX-XXXX> **Submit all Behavioral Claims to** Carelon

Submit Claims to:
Optimum HealthCare
Claims Department
P.O. Box 151258
Tampa, FL 33684
EDI Payer ID: <XXXXX>

H5427_MAPD_ID_CARD_2024

FREEDOM HEALTH

RxBIN#: <XXXXXX> RxPCN#: <XXX>
RxGrp#: <XXXXXXXX> Issuer#: <XXX>
RxID#: <Insert member ID#>

<INSERT PLAN NAME>

ID: <0000000000>
<FIRST><MI><LAST>

Eff. Date: <xx/xx/xxxx>
PCP: <FIRST><LAST>
Phone: <xxx-xxx-xxxx>

MedicareRx
Prescription Drug Coverage

H5427 - PBP - <xxx>

PCP Office Visit: <$> Urgent Care: <$>
Specialty Office Visit: <$> ER: <$>

Member Services: <X-XXX-XXX-XXXX>
TTY/TDD: <X-XXX-XXX-XXXX> www.freedomhealth.com

Provider Services (UM): <X-XXX-XXX-XXXX>
24/7 Nurse Advice Line: <X-XXX-XXX-XXXX>
Pharmacy Member Services: <X-XXX-XXX-XXXX>
Pharmacy Technical Support: <X-XXX-XXX-XXXX>
Behavioral Health *(Carelon)*: <X-XXX-XXX-XXXX> Submit all Behavioral Claims to Carelon

Submit Claims to:
Freedom Health
Claims Department
P.O. Box 151348
Tampa, FL 33684
EDI Payer ID: <XXXXX>

SPECIALTY MEDICATION REQUEST FORM

ALL REQUIRE MEDICAL RECORDS TO BE ATTACHED

Phone: (888) 796-0947
Fax: (888) 736-1123 or (813) 506-6226

INSTRUCTIONS

This form is for pre-certification **J** code requests under the Part B benefit (i.e. outpatient, in-office, or home health administration) and will be processed as quickly as possible depending on the member's health condition.

PLEASE FAX ALL SUPPORTING DOCUMENTATION: Clinical notes, laboratory results, creatinine clearance, cultures and sensitivities, etc.

IMMEDIATE OR EXPEDITED REQUESTS: Do not write STAT, ASAP or Immediate on this form. Please follow the instructions below. Medicare defines expedited as a request where "applying the standard time for making a determination could jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function."

ONLY COMPLETE THIS SECTION FOR EXPEDITED REQUESTS

If the PHYSICIAN feels the member meets this definition, please either:

1. Have the **PHYSICIAN call (888) 796-0947** to speak with our Medical Director to expedite your request, **or**
2. Have the **PHYSICIAN document the reason he/she feels the member meets the Medicare definition of expedited.**

_____

_____

Date of Request:	**(Circle County)**						
	Brevard	Citrus	Hillsborough	Manatee	Osceola	Polk	Sumter
	Broward	Collier	Indian River	Marion	Palm Beach	Sarasota	Volusia
	Charlotte	Dade	Lake	Martin	Pasco	Seminole	
		Hernando	Lee	Orange	Pinellas	St. Lucie	

Member Information:

Member Name	
Member ID#	
Member Address	
City, State, Zip	
Phone	
DOB	
Ht/Wt (lb/kg)	
Allergies	
DX	

Requesting Office:

Provider (PCP) Name	
TIN# / NPI#	
Phone	
Fax	
Contact Person	

Ordering Physician:

Name	
TIN# / NPI#	
Phone	
Fax	

- **Requests for Procit, Epogen, and Aranesp REQUIRE laboratory results within 30 days prior to the request.**
- **Red Cell stimulators will be approved for 60 days then additional lab results are required.**
- **Iron requests REQUIRE iron panel (iron saturation %, Ferritin, TIBC) within 60 days.**

(Please use another form if more lines are needed)

HCPCS Code(s)	Medication	Dose	Start Date	Frequency	Length of Treatment

Signature of ordering physician: _____ **Date:** _____

Please answer all of the questions below for a thorough review.

1. Is the medication being administered in the physician's office? ❑ Yes ❑ No
   - Will the Physician "Buy and Bill" (Physician will be responsible to collect co-payment)? ❑ Yes ❑ No
   - Does the office administering the medication need the medication shipped to them by the Plan's preferred pharmacy (pharmacy is responsible for collecting the medication co-payment)? ❑ Yes ❑ No
2. Is the medication being administered at a facility or outpatient center? ❑ Yes ❑ No
   (circle one) Facility/Outpatient Clinic Name/Skilled Nursing Facility Facility/Clinic Provider Name & ID#: _____
3. Is the medication being administered in patient's home? ❑ Yes ❑ No

Incident Report Form

Incident involves: ☐ Member ☐ Provider ☐ Other

Member Information: Member Name _____ DOB_____ Sex: ☐ M ☐ F

Member ID:_____

Plan: ☐ Optimum ☐ Freedom ☐ Other_____

Provider Information: Name_____

Clinic/Facility Name:_____

Address:_____

Incident information: Time_____ Date: _____ Location:_____

Date of Incident Identification: _____ _____

Description of Incident: (Provide a clear, concise description of incident; attach information if more space needed)

_____

_____

_____

Physician called: ☐ Yes ☐ No ☐ Name of physician: _____

Physician Statement/Recommendation: _____

Hospitalization required? ☐ Yes ☐ No

Facility Name:_____ Phone:_____

Address:_____

Admission Date:_____ Admission Time:_____

Member Admission Diagnosis: _____

Witnesses:

Name_____ Phone: _____

Address:_____

Corrective action taken:_____

<u>Report prepared by</u>:

Print Name: _____ Date: ___/___/___ Time: _____

Signature: _____ Position:_____ Department: _____

Date Notification to Risk Manager: _____ (within **<u>one</u>** working day of notification)

Risk Management Use: ICD10-CM Codes:

Waiver of Liability Statement

Enrollee's Name _____ Enrollee ID Number _____

Provider _____ Dates of Service _____

Health Plan _____

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature _____ Date _____

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

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

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

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

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

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

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

Approval of Fee

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

Conflict of Interest

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

Where to Send This Form

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

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

Cultural Competence for Provider Orientation

What is Cultural Competency?

- Cultural Competency is defined by the Department of Health and Human Services' Office of Minority Health as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in crosscultural situations."
- Culture includes a person's beliefs, values, customs, thoughts, actions, language, race, ethnicity, religion, and social groups.

Examples of Freedom Health Culturally Competent Services:

- Free language interpreter services for non-English speakers available through our Member Services Department:

  Freedom Health at 1-800-401-2740 TTY 711.

Notes: We have provided your office with a provider manual, quick reference guide, formulary and our laboratory provider draw centers. You will also find here and in your information, ways to reach us.

How can you incorporate Cultural Competency into your practice?

- Provide signs and educational materials with easy-to-read text written in common

languages encountered in your service area.
- Utilize nonverbal methods of communicating (e.g., pictographic symbols) with patients who cannot speak English or whose primary languages may not be English.
- Speak slowly and clearly in terms the patient will understand.
- Learn about and respect patients' values, beliefs, and lifestyle choices. Explain that this communication helps you diagnose and treat patients' illnesses or conditions.
- Be aware that direct or prolonged eye contact is considered disrespectful or aggressive in some cultures.
- Be aware that personal space requirements vary by culture.

For more information:

- U.S. Department of Health & Human Services' National Standards on Culturally and Linguistically Appropriate Services (CLAS).
- Office of Minority Health has Continuing Education Resources including the A Family Physician's Practical Guide to Culturally Competent Care Module.
- Health Resources and Services Administration (HRSA) of the U.S. Department of Health & Human Services website for Culture, Language and Health Literacy.

Last updated 10/01/2023

Helpful Links

CMS Model Electronic Complaint Form

The Medicare Beneficiary Ombudsman

Unable to view PDFs?

Disaster and Emergency Declaration Policy

Multi-Language Interpreter Service

Servicios de interpretación en varios idiomas
(Multi-Language Insert) | (Inserción de varios idiomas)

Section 1557 Notice of Non-Discrimination:
English | Spanish

Hours
From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. EST.

From April 1 to September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. EST.

Telephone 

Toll Free 1-800-401-2740
TTY/TDD: 711

Mailing Address
P.O. Box 151137
ATTN: Freedom Health
Tampa, FL 33684

Service Counties

SERVING THE FOLLOWING AREAS IN FLORIDA:

Brevard County

Broward County

Citrus County

Charlotte County

Collier County

Hernando County

Hillsborough County

Indian River County

Lake County

Lee County

Marion County

Manatee County

Martin County

Orange County

Osceola County

Palm Beach County

Pasco County

Pinellas County

Polk County

Saint Lucie County

Sarasota County

Seminole County

Sumter County

Volusia County

Website Disclaimer

Freedom Health, Inc. is an HMO with a Medicare contract and a contract with the state of Florida Medicaid program. Enrollment in Freedom Health, Inc. depends on contract renewal. This Information is not a complete description of benefits. Call 1-800-401-2740 (TTY: 711) for more information. Medicare beneficiaries may also enroll in Freedom Health through the CMS Medicare Online Enrollment Center located at http://www.medicare.gov . Every year, Medicare evaluates plans based on a 5-star rating system.

Freedom Health, Inc. has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Chronic Condition Special Needs Plan (C-SNP) through 2024 and a Dual Special Needs Plan (D-SNP) through 2026 based on a review Freedom Health, Inc.’s Model of Care.

Freedom Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Freedom Health, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Freedom Health, Inc. konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-401-2740 (TTY: 711). Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-401-2740 (TTY: 711).

These materials may be made available in alternate formats (e.g., large print, Braille) to individuals with disabilities, upon request.

RETURN TO TOP