

CHILDREN'S MEDICAL SERVICES

Provider Management

PROVIDER HANDBOOK

LICENSED NON-PHYSICIAN HEALTHCARE PROFESSIONALS

2009



TABLE OF CONTENTS

Introduction	Page
• Purpose.....	1
• Statutory Authority.....	1
• Mission Statements.....	1
• CMS Program Overview	1
• Organizational Structure	1
• Program History	2
General Provisions - CMS Network	
• Access to Care.....	5
• Authorizations/Referrals.....	5
• Reimbursement.....	5
• Claims Submission.....	6
• Records/Quality Assurance.....	7
• Malpractice Coverage	7
• Dispute Resolution	8
• Termination from Participation	8
• CMSN Complaint & Grievance Policy & Procedures	8
• Federal Anti-kickback Law	8
Specialty Program Provisions	
• Early Steps.....	9
▪ ES Licensed Healthcare Professional Provider Standards	9
▪ ES Access to Care	9
▪ ES Provider Requirements.....	10
▪ ES Terms & Conditions	11
▪ ES Authorization & Referrals.....	12
▪ ES Reimbursement	12
▪ ES Claim Submission.....	12
Discipline Specific Requirements	
• Audiologists	
▪ CMS Participation Criteria	13
▪ Pricing Recommendations	15
• Physician Extenders	
▪ Definitions.....	18
▪ CMS Participation Criteria	18
▪ CMS Participation.....	18
▪ Physician Extender Reimbursement	19
▪ Medicaid Reimbursement Policy	20
▪ Physician Extender Participation Status.....	22
Application & Approval Process	
• CMS Participation Criteria	23
• Application Process.....	23

CMS PROVIDER HANDBOOK
LICENSED HEALTHCARE PROFESSIONALS
TABLE OF CONTENTS
PAGE ii of ii

- Initial Approval Process.....24
- Participation Status24
- Renewal Process25
- Ad-hoc Reviews26
- Termination26

Provider Review Committee

- Function28
- Committee Composition28
- Meeting Process28
- Frequency of Meetings.....29

Provider Rights

- Right to Review30
- Notification30
- Right to Hearing31
- Right to Appeal.....32
- Notice of Administrative Rights32

INTRODUCTION

Purpose

This handbook was developed to provide CMS licensed healthcare professionals an overview of Children's Medical Services programs and provider participation criteria and requirements.

Statutory Authority

Children's Medical Services (CMS): Chapter 391, Florida Statutes (F.S.)

- Florida KidCare: Chapters 391.026 and 409.813-409.814, F.S.
- Titles V, XIX, and XXI, Social Security Act

Child Protection Team (CPT) Program: Chapter 39.303, F.S.

Regional Perinatal Intensive Care Centers (RPICC): Chapter 383.15-21, F.S.

Early Steps (ES): IDEA, Part C, 34 CFR Part 303

Mission

Champion excellence in the delivery of health care to children with special needs through a comprehensive system of care; and

Promote the safety and well being of Florida's children by providing specialized services to children with special health care needs or those who have been alleged to be abused or neglected.

CMS Program Overview

Children's Medical Services provides a comprehensive continuum of medical and supporting services to medically and financially eligible children and high-risk pregnant women. The continuum of care includes prevention and early intervention services, primary care, medical and therapeutic specialty care and long-term care. Services are provided through an integrated statewide system that includes local, regional, and tertiary care facilities and providers.

Primary care is the well-child and acute care component of the Children's Medical Services Network. CMS uses a private practice model that ensures 24-hour access to primary care physicians and linkages into secondary and tertiary care providers.

The CMS system of care also includes a wide range of specialty services and long-term care services for medically complex or medically fragile children and high-risk pregnant women. Long-term care services include medical day care, medical foster care, nursing home care, and in-home care.

Organizational Structure

Children's Medical Services, a program of the Florida Department of Health (DOH), is directed by the CMS Deputy Secretary of Health. This individual is a physician experienced in providing pediatric medical care with skills in leadership, administration and promotion of children's health care programs. The CMS Program is divided into two divisions, the Division of CMS Network and Related Programs and the Division of Prevention and Intervention.

The Division of CMS Network and Related Programs include 22 CMS area offices throughout the state. The CMS area offices are administered by a Medical Director who is a physician within the community. Staff at each area office include a nursing director, program administrator, nurses, care coordinators, social workers, financial counselors, and support personnel. CMS staff is available to assist families in accessing a continuum of community and state services that address the clinical and/or developmental needs of infants, children, adolescents, young adults, and pregnant women. These programs and services are provided primarily through private and contracted providers. In addition to many regional specialty medical programs, developmental services are accessed through Early Steps (ES) providers affiliated with the 15 Local Early Steps Offices located throughout the State.

The Division of Prevention and Intervention administers the Child Protection Team (CPT) Program. The Child Protection Team Program is statewide and consists of 21 teams and three satellite sites. A Child Protection Team Medical Director heads each team.

Funds for administering the CMS Program are derived largely from state tax dollars. Other sources of funds include the Federal government, third party collections and private donations.

Program History

1929 - The Florida Legislature enacted Chapter 13620 of the Florida Statutes establishing the Florida Crippled Children's Commission (FCCC). The mission of the FCCC was to organize and initiate a program of medical care for indigent, crippled children "ensuring that every indigent or partially indigent child in Florida might have promptly and efficiently the best surgical and medical care available in the State." This mission remained unchanged until 1975 when Chapter 13620, F.S. was revised (and renumbered to Chapter 391) to create a separate program for crippled children with an increased emphasis on planning, coordinating, improving and administering medical care programs for children who were at risk for handicapping conditions. This new mission reflected a change in philosophy and vision about the purpose of the organization and recognized the need to expand services to a broader population of children.

The original 1929 FCCC legislation empowered a Governor-appointed five member Commission to establish decentralized medical care programs for indigent, crippled children. The first Commission members served without pay and, through their interest, personal dedication and commitment to rehabilitate the crippled child, laid the foundation for building and developing the program of the Commission.

Initially, the FCCC divided the state into three patient service districts: north, central and south Florida. Each district was served by a private-practicing orthopedic surgeon who was responsible for establishing medical clinics that served as locations to evaluate and treat crippled children and entering into contracts with hospitals. Private sector physicians provided medical services at the clinics and a small number of state employed nurses who assisted the physicians in the clinics. In 1931, guided by the recommendations of the American College of Surgeons, American Hospital Association, and the State Board of Health, the Commission designated medical centers throughout the state.

1935 - With the passage of Title V of the Social Security Act, federal financial support was made available to the FCCC to expand the geographic and programmatic scope of the program.

1969 - A newly developed “umbrella agency” entitled the Department of Health and Rehabilitative Services (HRS) was created. The FCCC was transferred to HRS, the Commission became a statewide advisory council. District medical advisory committees were formed for the purpose of providing advice to local programs. The medical care program became known as the Bureau of Crippled Children’s Services (CCS) and was administratively located within the HRS Division of Vocational Rehabilitation. A headquarters office was created to centralize control and authority of the CCS program with a physician directing staff functions in this office.

In December 1969, Florida committed itself to participate in the federal Medicaid program. As part of that commitment children were given additional coverage under a federal mandate referred to as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

1971 - Florida Statutes first required mandatory reporting of suspected child abuse and neglect and required a determination of harm or threatened harm to each child and the nature and extent of injuries, abuse, or neglect. The then Department of Health and Rehabilitative Services (HRS) recognized the need for a specialized medical resource and developed a plan that included designating Children’s Medical Services as the appropriate program to address this need. The plan resulted in a pilot project using a medically directed, multidisciplinary team approach, and was funded in 1978. The success of this pilot led to legislative funding of several more teams and statewide coverage existed by the end of the 80s. One more team was added in 1995 for the new HRS District 15.

1973 - CMS became a division within HRS and was required as a result of a lawsuit, to develop a uniform program throughout the State that would accept every child who was financially eligible for the program, regardless of cost, within the fiscal limitations of the Division.

1974 – RPICC Program was initially funded for five hospital neonatal intensive care centers. Eventually funding expanded to include eleven centers by 1994 with reimbursement through Medicaid using the Obstetrical Care Group (OBCG) and Neonatal Care Group (NCG) in 1989. RPICC Program funds include high-risk obstetrical satellite clinics, transport services, statewide consultants and data services.

1975 - HRS was reorganized and, as a result of amendments to Chapter 391, F.S., CCS was renamed Children’s Medical Services (CMS) and became a separate program. The 1975 revisions of Chapter 391, F.S. marked the beginning of the program’s accelerating growth and expansion. This growth and expansion can be credited to several factors. First, the program’s statutory base fostered expansion to meet the growing needs of an increasing population. Second, the program maintained strong leadership through a private practicing physician director. Third, prominent pediatricians provided a strong advocacy base that promoted and supported an expanded vision for the program on behalf of children with crippling conditions. Fourth and finally, it successfully organized a public-private partnership that fostered early identification of children with chronic illnesses and provided quality, effective care for those children.

1996 – The Department of Health was created and Children’s Medical Services was transferred to the newly established department. The CMS Network was authorized as a Medicaid managed care option for children with special health care needs.

1997 – The division director position for Children’s Medical Services was changed to a Deputy Secretary for Children’s Medical Services and two divisions were established in the Children’s Medical Services Program.

1998 – The CMS Network was authorized as a KidCare plan for children with special health care needs who qualified for Title XXI federal funds.

2006 – CMS was designated as a Medicaid provider service network under Medicaid Reform.

Role and Scope

The primary role of the CCS program from the 1930’s through the 1960’s was that of a direct service provider and a prescribed health care manager. Secondary roles included those of a provider of medical services and consultation and a broker of services with the private sector.

With revision of the legislation in 1975, the program acquired several additional roles. It became an advocate for chronically ill children and substantially expanded its direct service, prescribed health care management, and broker of services roles. In addition CMS began to develop standards for the provision of care and to promote and develop regionalized systems of care through large hospital and medical centers in the state.

Primary care was added to the service system in the 1980’s and Medicaid expanded its benefit package in 1990 to cover a wide range of services for children with special health care needs.

Today, Children’s Medical Services provides a comprehensive array of services through private sector providers. The CMS Program is the principle service delivery system for children with special needs and high-risk pregnant women who meet established criteria.

GENERAL PROVISIONS - CMS NETWORK

The CMS Network is a comprehensive, managed system of care for children under age 21 with special healthcare needs who are enrolled in the CMS Network. The CMS Network includes Early Steps (Florida's early intervention system under the Individuals with Disabilities Education Act (IDEA), Part C), the Florida Newborn Screening Program, Florida's Medical Foster Care Program, CMS Regional Perinatal Intensive Care Centers Program, and many other specialty programs for children with medical, behavioral, and developmental needs.

Access to Care

Participating CMS providers agree to provide or arrange to provide all medically necessary covered services including emergency services to CMS enrolled children referred to the provider. The provider will render covered services to CMS enrolled children in an efficient and professional manner, which at a minimum shall be in accordance with the same standards and time availability as offered to non-CMS children.

Participating CMS providers agree to provide covered services to all assigned or referred CMS children. The provider will neither differentiate nor discriminate in the treatment of or in the quality of medical services delivered to CMS children on the basis of race, color, national origin, religion, disability or gender. Providers will ensure services are family centered, inclusive, culturally competent, and include family members as an integral part of service planning, implementation and on-going assessment.

Providers may not refuse to provide a covered service to assigned CMS children, as long as the services are within the providers' capabilities and resources.

Authorizations and Referrals

Referral services for CMS Network enrolled children are prior authorized by the child's primary care physician.

If the healthcare professional provides services to a CMS child who is enrolled in the Medicaid program, the provider will be bound by laws and regulations administered by the Florida Agency for Health Care Administration (AHCA).

Reimbursement

Services will be compensated based on the client's funding source.

Medicaid Clients

All Medicaid covered services are to be billed to Medicaid or Medicaid managed care entity in which the child is enrolled. Services not covered by Medicaid may be provided with the approval of the local CMS Medical Director, if the services are determined to be medically necessary. Documentation of medical necessity will be required.

There are no co-payments or deductibles in this program.

KidCare Title XXI Clients

The Medicaid benefit package is used. Services are to be billed to the local CMS area office. Services not covered under the Medicaid benefit package may be provided with the approval of the local CMS Medical Director, if the services are determined to be medically necessary. Documentation of medical necessity will be required.

There are no co-payments or deductibles in this program.

Private Insurance

The specific plan benefit package is used. Services are to be billed to the private insurer. Services not covered by private insurance may be provided with the approval of the local CMS Medical Director, if the services are determined to be medically necessary. Documentation of medical necessity will be required.

Applicable co-payments and deductibles will apply. The family is generally responsible for meeting the deductible or covering the co-payment.

Reimbursement Rates for CMS Network Clients

Except for services covered by private insurance, Medicaid reimbursement rates are used for all other services provided to CMS Network clients regardless of funding source. Medicaid policy is used with regard to service coding and coding appropriateness. Medicaid reimbursement rates are defined as:

- The published current year Medicaid rate for the provided service.
- The rate Medicaid would pay for a prior approval, by report, or miscellaneous coded service using Medicaid policy.

Provider services that do not have Medicaid rates, under special situations approved by the local CMS Medical Director, will be reimbursed at no more than 60% of the provider's usual and customary fee.

Claims Submission

Providers should submit claims for payment within 90 days of the date of service.

Providers may not receive dual compensation for the interpretation of diagnostic tests during a clinic visit.

Florida Statutes mandate that CMS funds are residual to all other resources. Therefore, CMS providers must bill third party payers, including Medicaid, before seeking reimbursement from Children's Medical Services.

CMS or Medicaid Funding

When State funding for a service is accepted as payment by a provider, that reimbursement must be considered "payment in full". Neither the client or family nor third party payers can be billed for the balance of the service.

Private Insurance

When third party reimburses a provider less than the Medicaid rate, CMS may be billed for the difference up to the allowable Medicaid rate. Clients or families may not be additionally billed for the services.

Records and Quality Assurance

The provider will maintain client records in a manner that is current, detailed, and organized and permits effective and confidential patient care.

The provider will maintain records and information including, but not limited to, information relating to the provision of covered services to CMS children, the cost of said services, and payment received by the provider on behalf of the client.

The provider will make medical records available to other healthcare providers, subject to applicable confidentiality requirements, when such records are necessary for evaluating and treating the client.

Patient records must be retained for at least five (5) years from date of service.

A CMS client's records will be made available to the client or their family (for dependent children) upon request. Applicable records request fees may apply for copies of such records.

Provider's records will be made available for review to CMS as may be necessary for quality assurance reviews or as may be necessary to comply with the provisions of Florida laws and regulations.

Participating CMS providers agree to remain licensed to practice their discipline in the State of Florida and shall comply with all laws and regulations pertaining to such practice. Providers are required to comply with CMS approval and renewal processes to maintain active CMS provider participation status.

Malpractice Coverage

Solo providers shall maintain individual professional liability insurance coverage or otherwise maintain and be able to demonstrate compliance with the mandatory financial responsibility requirements and policies relating to those engaged in the provision of healthcare as set forth in the provider's relevant practice act in the Florida Statutes.

Under certain circumstances for services provided within the scope of the provider's participation in the CMS network on a case by case basis, the provider may be considered an agent of the state within the meaning of Section 768.28, Florida Statutes (Sovereign Immunity).

It is a matter of prudence and good sense, as well as in the best interests of CMS and the provider that CMS healthcare providers carry appropriate insurance for their own protection in the event that the provider is sued and is determined by the courts to not be agents of the state under the circumstances of the particular lawsuit.

In the event of a lawsuit, however, the Department of Health will continue its practice to evaluate each case on its own merits and particular factual circumstances. Invariably, the Department has provided such assistance as it can under the particular circumstances of each case. In appropriate cases, such as *Stoll v. Noel*, the Department can add its voice to the proposition that the provider should be considered an agent of the state under the facts and circumstances of the particular case.

Dispute Resolution

With exception of professional malpractice issues, the parties shall first attempt in good faith to resolve any dispute, controversy, or claim arising out of the professional relationship between the provider and CMS. In the event that the dispute remains unresolved, the provider should contact the local CMS Medical Director or local Early Steps Director. *Refer to Complaint & Grievance Policy & Procedure Section.*

Termination from Participation

In the event that a provider's participation with CMS is terminated by either the provider or by CMS, notice shall be provided to the other party and to CMS clients receiving services from the provider.

Complaint & Grievance Policy & Procedure

For Medicaid provider issues involving eligibility or reimbursement, the provider must utilize the Medicaid Program grievance procedure to access the Florida Division of Administrative Hearings or the court system.

For complaints regarding CMS Area Office issues, please contact the CMS Medical Director for the specific office. For complaints regarding local Early Steps issues, please contact the local Early Steps Director.

Federal Anti-kickback Laws

Each provider will have read and understands the federal requirements outlined in 42 CFR 1001.1001 and 1001.1051 and 42 USC 1320a -7b (criminal penalties for acts involving Federal health care programs). <http://oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm>

EARLY STEPS

In addition to the information outlined in the General Provisions - CMS Network section, licensed healthcare professionals participating in the Early Steps (ES) program will meet and comply with the following ES specific criteria and requirements.

Early Steps is administered by Children's Medical Services in accordance with Part C of the Individuals with Disabilities Education Act (IDEA). Early Steps offers early intervention services for families with infants and toddlers (birth to thirty-six months) who have developmental delays or an established condition likely to result in a developmental delay. Fifteen contracted local Early Steps offices across the state coordinate with community agencies and other contracted providers for the delivery of needed supports and services.

Local Early Steps (LES) offices also implement the Developmental Evaluation and Intervention Programs (DEI) to identify and serve at risk infants in neonatal intensive care units, based on the availability of funds.

Florida has a wide range of children and families, providers, community programs and agencies that comprise the early intervention system. Given the diversity in Florida regarding socioeconomic levels, geographic location, cultural, linguistic, and ethnic backgrounds, as well as diversity in disability type, personnel development must include knowledge and skills adequate to meet the needs of a broad range of children and families. The service delivery system is family-centered and focuses on young children with special needs and their families. Services accommodate families by being flexible, individualized, and respectful of cultural diversity and support families to mobilize their resources to meet their needs.

Early Steps Licensed Healthcare Professional Provider Standards

All Early Steps licensed healthcare professionals providing direct services or oversight functions for children enrolled in Early Steps must be an active member of the CMS Provider Panel, and are therefore subject to the requirements and processes outlined in this handbook for attaining active CMS participation status.

Once a licensed healthcare professional has achieved active CMS participation status, those professionals wishing to provide early intervention services will be required to complete specific Early Steps orientation and training requirements. More information on these requirements may be found at www.cms-kids.com

Access to Care

Participating CMS Early Steps providers will neither differentiate nor discriminate in the treatment of or in the quality of services delivered to Early Steps clients on the basis of race, color, national origin, religion, disability or gender. Providers may not refuse to provide a covered service to assigned or referred Early Steps clients, as long as the services are within the providers' capabilities and resources.

Participating providers must agree to provide services in accordance with Part C of the Individuals with Disabilities Education Act (IDEA) and Early Steps policy.

Early Steps Provider Requirements

Below is a listing of Early Steps specific provider requirements that are needed in addition to the submission of an electronic application and supplemental documentation that is required as part of the Children's Medical Services provider enrollment process at: www.cmskidsproviders.com

1. Provider Type

Licensed Health care professionals are not eligible to enroll as an Infant Toddler Developmental Specialist (ITDS). *Refer to Non-licensed Provider Handbook*

2. Experience

One year of post-degree professional experience in early intervention.

3. Medicaid Number

- a. Medicaid numbers (therapy, TCM, or EIS) are not required prior to CMS/ES temporary (one year) approval. (Refer to *Application and Approval Process* section)
- b. Current, active Medicaid numbers are required prior to working in CMS/ES if serving Medicaid children.
- c. For those providers in temporary status, at the time of their renewal, if they have not obtained the appropriate Medicaid numbers, they will be removed from Early Steps participation.

4. Level II Background Screening (as required in s. 393.0655, F.S.)

- a. Documentation of clear background screen is required for all provider types prior to both CMS/ES approval and prior to working in the Early Steps System.
- b. A level II background screen may be documented in the one of the following ways:
 - Valid, active Medicaid provider number (clear background screen is a Medicaid requirement)
 - Copy of clear Level II Background Screen that is less than 5 years old

5. Relationship with Local Early Steps (LES) Office

- a. Documented relationship with an LES is not required prior to CMS approval except for those providers who have less than one year of direct service experience in early intervention with infants and toddlers.
- b. Documented relationship with an LES is required prior to working in the Early Steps system.

6. Mentorship

- a. Mentorship is required for providers (except associates and assistants) who do not have one year of post degree professional early intervention experience.
- b. *Speech Language Pathologists* with provisional license and *Therapy Assistants* are required to have one year of experience; mentorship is not an option.
- c. Completion of mentorship is not required prior to CMS/ES temporary approval but a documented relationship with their LES is required.
- d. Completion of mentorship is not required prior to working in the Early Steps system.
- e. Mentorship must be provided by an approved CMS/ES provider of the same discipline who is working in the Early Steps system.
- f. Mentorship must be completed within six months of contract or hire by the local Early Steps agency.
- g. For those providers in temporary status, at the time of their renewal, if they have not completed their mentorship, they will be removed from Early Steps participation.

7. Orientation Modules

- a. Completion of Early Steps Orientation Modules is not required prior to CMS/ES temporary approval.
- b. Completion of ES Orientation Modules is required prior to working in the Early Steps system.

8. Continuing Education Units (CEU)

- a. Thirty six (36) hours of early intervention specific continuing education units are required for CMS/ES renewal.
- b. Licensed healthcare professionals will be subject to random audit of their early intervention specific CEUs at the time of renewal.

Terms & Conditions

As an approved CMS Early Steps provider, the following terms and conditions will apply:

1. CMS approved Early Steps healthcare professionals are eligible to provide services in the Early Steps system through a provider agreement with a Local Early Steps program.
2. Local Early Steps programs are under no obligation to employ or contract with a licensed health care professional based solely on the fact that the professional has been approved as a CMS Early Steps provider.

Authorizations/Referrals

Approved CMS Early Steps healthcare professionals will provide early intervention services as authorized by the Local Early Steps (LES) offices and through the child's Individualized Family Support Plan (IFSP).

For services provided to CMS Early Steps children who are enrolled in the Medicaid program, the provider will be bound by laws and regulations administered by the Agency for Health Care Administration (AHCA).

Early Steps Evaluation Services

All Early Steps providers who participate in and bill Medicaid for early intervention evaluations must be enrolled as a Florida Medicaid Early Intervention Services (EIS) provider.

Reimbursement

Refer to Component 1 of the Early Steps Handbook and Operations Guide at http://www.cms-kids.com/resources/es_policy/index.html

Claims Submission

Providers should submit claims for payment within 90 days of the date of service.

Part C of the Individuals with Disabilities Education Act (IDEA) mandates that CMS Early Steps funds are residual to all other resources. Therefore, CMS Early Steps providers must bill third party payers, including Medicaid, before seeking reimbursement from CMS Early Steps (Part C). When Part C funding for a service is accepted as payment by a provider, this reimbursement must be considered "payment in full". Neither the family, nor third party payers, can be billed for the balance of the service.

Additional information related to this topic may be found in Component 1 of the Early Steps Handbook and Operations Guide.

DISCIPLINE SPECIFIC REQUIREMENTS

In addition to the information outlined in the other sections of this Handbook, Licensed Healthcare Professionals listed in this section will meet and comply with the following CMS criteria and requirements for their discipline.

AUDIOLOGISTS

CMS Participation Criteria

Audiologist must provide information on the following:

Experience and Caseload

- Children under 12 Months of Age
 1. At least one year of experience as a licensed audiologist;
 2. A minimum caseload of children under three years of age that comprises a minimum of 10% of total caseload;
 3. A minimum diagnosis of hearing loss in at least five children younger than 12 months; and
 4. Hearing aid fitting for at least three children who are 12 months or younger or an agreement with another CMS approved audiologist to refer to for hearing aid fitting.
- Children over 12 Months of Age
 1. At least one year of experience as a licensed audiologist;
 2. A minimum caseload of children that comprises a minimum of 25% of total caseload; and
 3. Successful completion of hearing evaluation for a minimum of 20 children per year who have craniofacial anomalies and/or neurodevelopmental disorders.

Protocols

- Children less than 12 Months of Age
 1. If failed one newborn hearing screening then screening or diagnostic OAE or screening click AER;
 2. If failed two hospital newborn hearing screenings then diagnostic OAE (2000-6000 Hz) or air conduction click AER;

3. If abnormal or inconclusive OAE results then high frequency tympanometry and air conduction click AER;
 4. If air conduction click AER is abnormal then bone conduction click AER and 500 Hz, 2000 Hz, 4000 Hz tone burst AER and/or steady state response (ASSR);
 5. If permanent hearing loss is confirmed obtain medical clearance for amplification fitting when appropriate and use probe microphone measures as a component of hearing aid fitting;
 6. Results (normal and abnormal) for children referred from newborn hearing screening will be reported to the state CMS Newborn Screening Program.
- Children over 12 Months of Age
 1. Tympanometry, screening or diagnostic OAE, ear specific air conduction and bone conduction testing (VRA, conditioned play audiometry, or standard audiometry);
 2. OAE, AER as necessary to determine peripheral and/or neural auditory status;
 3. Speech detection/reception threshold, word discrimination testing;
 4. If permanent hearing loss is confirmed perform speech in noise testing (+5 S/N, +10 S/N);
 5. Obtain medical clearance for amplification fitting when appropriate and use probe microphone measures as a component of hearing aid fitting;
 6. Any child less than age 3 years of age with a diagnosis of permanent hearing loss in one or both ears will be reported to the state CMS Newborn Screening Program.

Reports

- Children less than 12 Months of Age

Example of reported diagnostic findings of at least one child less than six months of age with **all personal identifying information redacted**. The report(s) should focus on diagnostic evoked potential results, preferably with frequency specific information and one or more of the following: OAE, high frequency tympanometry, BOA/VRA, probe microphone and/or amplification recommendations. The report should be prepared and signed by the applicant and be one of the applicant's clients.

- Children over 12 Months of Age

Example of reported diagnostic findings of at least one child greater than 12 months of age with **all personal identifying information redacted**. The report(s) should focus on diagnostic results with frequency specific information and include ear-specific air conduction and bone conduction information, speech detection, tympanometry, and middle ear muscle reflex results (if performed). AER and/or OAE tracings should also be included if performed.

Report should specify probe microphone and/or amplification recommendations. The report should be prepared and signed by the applicant and be one of the applicant's clients.

Equipment Requirements

The following is a list of equipment required for evaluating young children or those with substantial developmental delays. As part of CMS ongoing quality assurance audiology facilities may be required to submit evidence to verify the presence of this equipment.

- Minimum equipment
 1. Diagnostic Auditory Evoked Response (AER) equipment (bone conduction, click, tone burst capability)
 2. Impedance bridge (Audiologists evaluating children under 12 months of age must have impedance bridge capability to perform high frequency probe tone for tympanometry for 0-6 month old babies)
 3. Screening or diagnostic otoacoustic emissions equipment (distortion product or transient)
 4. Probe microphone system for Real Ear measures on infants OR an established referral protocol to a pediatric audiologist who fits infants with amplification
 5. Visual Reinforcement Audiometry equipment

- Additional Preferred Equipment
 1. Diagnostic otoacoustic emissions equipment (distortion product or transient);
 2. Auditory Steady State Response equipment.

Pricing Recommendations

Pricing Exceptions for Hearing Aids

Auditory stimulation under the age of three years is required for development of synaptic connections within the auditory cortex, which are necessary for optimal acquisition of verbal language skills and elemental cognitive, social, and emotional development. Quality auditory stimulation is critical for children that have potential to use auditory input to develop verbal language skills.

Exclusions - When a child meets the following exclusions it is appropriate to consider purchase of amplification above the current maximum Medicaid rate. *This only applies to children who are NOT Medicaid eligible and who have no other source of payment for amplification devices.*

- Age Birth to 13 Years
 1. If a child has useable residual hearing (average hearing loss at 500, 1000, 2000 Hz between 20-85 dB HL) AND has the potential for the development of language skills through the use of the auditory channel then high quality amplification (i.e. digital signal processing) technology is appropriate.

2. If a child has very limited residual hearing (average hearing loss in excess of 85 dB HL) AND/OR has little or no potential for the development of verbal language skills (i.e., severe cognitive delay affecting the development of speech understanding) then amplification devices that can be purchased within the current maximum Medicaid rate are appropriate.

- Age 13 to 21 Years

Hearing aid technology or amplification devices that can be purchased within the current maximum Medicaid rate are appropriate for children in this age range with the following exceptions that can be determined from the audiogram.

1. Reverse slope or cookie bite configuration: Child qualifies if there is at least one frequency below 2KHz with threshold greater than or equal to 20dBHL poorer than the threshold at either 2000 Hz or 4000 Hz.
2. Severe High frequency loss: Child qualifies if the difference in threshold between two adjacent frequencies is greater than 30dBHL
3. Steeply sloping/precipitous loss: Child qualifies if the difference between the threshold at 4KHz and either 1000 Hz or 2000 Hz is greater than 30dBHL.

Amplification Technology Funding

The cost of amplification technology has a wide price range. The following recommendations for funding are offered as a means to control costs and still provide appropriate amplification devices. The CMS Network and CMS Early Steps adhere to the funding policies below. Unlike adults and older children, many adjustments need to be made to the amplification devices as children grow in their first few years of life. Due to this, an allowance for hearing aid follow-up appointments is made in the funding recommendations.

1. Amplification Device: Medicaid rate for eligible children or reimbursement up to \$1000 total for two devices priced at single unit wholesale cost (does not apply to surgically implanted devices or devices that attach to surgical implants).
2. Ear Molds: reimbursed at Medicaid rate per ear mold. Maximum of 3 ear molds per ear allowed per year.
3. Fitting Fee: Paid at the current year maximum Medicaid rate; covers initial hearing aid fitting services per event (paid per hearing aid).
4. Hearing aid follow-up appointments* are necessary for appropriate fitting and maintenance of amplification in children. The maximum number of hearing aid follow-up appointments is determined by the age of the child. Hearing aid follow up appointments for children under age three years are reimbursable by Local Early Steps for children enrolled in early intervention services. Hearing aid follow up appointments for children ages 3-6 years or new hearing aid users from 6-21 years are reimbursable by the CMS Network for eligible children. Suggested maximum number of appointments is as follows:

- Maximum of 12 hearing aid follow-up appointments for infants between the ages of 1 month and 12 months.
- Maximum of 6 hearing aid follow-up appointments for toddlers between the ages of 13 months and 36 months.
- Maximum of 3 hearing aid follow up appointments for children between 3 years to 6 years of age or if child is a first time amplification user at 6 - 21 years of age.
- Suggested maximum number of follow up appointments can be exceeded based on the needs of the individual child.

*A hearing aid follow-up appointments will be conducted by an approved CMS audiologist provider and will contain at least two of the following activities that are not otherwise reimbursable by health insurance or another funding source:

- ear canal probe microphone measurements
- adjustment/programming of hearing instruments
- behavioral audiometric measurements
- electroacoustic hearing aid analysis
- validation measures
- in-office repairs of hearing instruments (not to include delivery after manufacturer repair)
- family training
- earmold impressions

PHYSICIAN EXTENDERS

Definitions

1. Physician Extender: Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA).
2. Advanced Registered Nurse Practitioner (ARNP): a Registered Nurse licensed under Section 464.008 or 464.009, F.S. and duly certified by the Board pursuant to Section 464.012, F.S.
3. Physician Assistant (PA): The individual must meet all the requirements of Physician Assistant licensure pursuant to Section 458.347(7) or 459.022(7), F.S.

CMS Participation Criteria

In addition to the information outlined in the Application and Approval Processes section physician extenders participating in the CMS will meet and comply with the following additional criteria and requirements.

Physician extenders must provide information on the following:

Years of Experience

- CMS Network - Documentation of three years experience in their area of practice, i.e., pediatrics, orthopedics, etc; national certification as an extender in area of practice may be substituted for one year of experience.
- Child Protection Team (CPT) - Documentation of one year of experience as a physician extender in pediatrics or family medicine.

Practice Protocols

- Practice Protocols established and signed by both the CMS approved supervising CMS or CPT physician and the physician extender.

CMS Participation

Physician Extenders may see CMS enrollees independently under the following criteria:

1. Physician extenders comply with all licensure requirements as outlined by the Department of Health Medical Quality Assurance.
2. Physician extenders provides services under a supervisory arrangement with an approved CMS physician;
3. The supervising physician has developed practice protocols for the physician extender, both ARNP and PA, within their scope of practice outlining the level of care the extender may

provide and the referral criteria for physician consultation and/or review. The protocols must be signed and dated by both the supervising physician and the extender.

4. Supervision
 - a. CMS Network ARNP/PA - The supervising physician is immediately available in person for consultation (or via telemedicine if functioning as an extender in a telemedicine clinic).
 - b. CPT ARNP - The supervising physician is available in person, by telephone or telemedicine consultation.
 - c. CPT PA - The supervising physician is immediately available in person.
5. Medical Records Review
 - a. CMS Network ARNP/PA - The supervising physician reviews each medical record of every CMS patient seen by a physician extender within 24 hours of the appointment.
 - b. CPT ARNP - The supervising physician reviews quarterly a random sampling of medical records of CPT patients seen by the ARNP.
 - c. CPT PA - During the initial six (6) months of supervision, medical records must be reviewed and signed by the supervising physician within seven (7) days. After the initial six month period, charts must be co-signed within 30 days;
6. Physician extenders approved for the Child Protection Team are not approved for CMS Network participation and vice versa.

Physician Extender Reimbursement

Clinic Services

CMS physician extenders may be reimbursed by either one of the following reimbursement options:

1. Flat Rate - Physician extenders working with CMS approved physicians will be reimbursed at 80% of the CMS Physician rate *or* \$108.00 per hour / \$54 per half hour.
2. Fee-for-Service – Fee-for-service reimbursement will be consistent with the Medicaid Reimbursement rate for specific services. Physician extenders working with CMS physicians will be reimbursed at 80% of the Medicaid physician reimbursement rate. The CMS physician cannot bill separately for services provided by the physician extender. If, due to the complexity or acuity of required services, the care of the patient is transferred to the CMS physician, the CMS physician may bill *only* the Physician Medicaid Reimbursement rate and the physician extender may not bill for any services provided to that patient at that specific visit.
3. Contract Funding – The physician extender’s salary is reimbursed fully, or partially, with CMS contract funds.

Physician Practice Sites

Fee-for-service reimbursement will be consistent with the Medicaid Reimbursement rate for specific services provided by physician extenders. When the physician extender sees the patient independent of the physician, the physician extender will be reimbursed at 80% of the Medicaid physician reimbursement rate. The CMS physician cannot bill separately for services provided by the physician extender. If, due to the complexity or acuity of required services, the care of the patient is transferred to the CMS physician, the CMS physician may bill *only* the Physician Medicaid Reimbursement rate and the physician extender may not bill.

Medicaid Reimbursement Policy

Advanced Registered Nurse Practitioner (ARNP)

In general, Medicaid reimburses for services rendered by a licensed, Medicaid-participating ARNP. The services must be rendered in collaboration with a physician licensed pursuant to Chapter 458 or 459, Florida Statutes. Reimbursement for anesthesia, obstetrical, and psychiatric services is limited to ARNPs who have completed the educational program in the appropriate specialty are authorized to provide these services by Chapter 464, Florida Statutes, and have filed protocols with the Board of Medicine. Medicaid reimburses ARNPs who are Medicaid-participating independent providers with formal relationships with Florida licensed physicians.

Medicaid reimbursement for ARNP services are limited to:

- One ARNP-recipient contact per day (except for emergencies);
- One long-term-care facility service, per ARNP, per month, per recipient (except for emergencies);
- Ten low-risk prenatal and two postpartum visits per pregnancy; and
- One new patient evaluation and management service, per ARNP, per recipient, every three years, if no services were rendered by the ARNP to the recipient during the three years. Subsequent encounters must be reimbursed as established patient evaluation and management services.
- Medicaid cannot reimburse an ARNP and a physician for the same procedure, same recipient, and same date of service. Medicaid may reimburse a surgeon for a surgical service and an ARNP for the assist-at-surgery service.
- The ARNP may request authorization for reimbursement for services in excess of the service limitations.
- Medicaid reimburses for ARNP services for all Medicaid recipients based on medical necessity.
- Medicaid reimbursement for ARNP services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. ARNPs are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services.

- If an ARNP is salaried by a hospital or other facility that is reimbursed on a cost-related basis, the ARNP cannot be paid on a fee-for-service basis if the costs for the ARNP salary are included in the facility's cost report.

Co-payments for ARNP services are not allowed for CMS enrollees.

- Scope of practice and specific questions and issues are addressed in the Florida Medicaid Advanced Registered Nurse Practitioner Coverage and Limitations Handbook.

Physician Assistant (PA)

Scope of practice and compensation regarding a PA is similar to the ARNP as described above. Medicaid reimburses for services provided by licensed, Medicaid-participating PA. The services must be provided in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, Florida Statutes.

Medicaid reimbursement for physician assistant services is limited to:

- One PA-recipient contact per day (except for emergencies);
- One long-term care facility visit per month, per recipient (except for emergencies); and
- One new patient evaluation and management service per PA, per recipient every three years, provided no services were rendered by the PA to the recipient during the three years. A supervising physician for a patient who has already been seen as a new patient by a PA may not bill new patient visits.
- Medicaid cannot reimburse a physician assistant and a physician for the same procedure, same recipient, and same date of service. Medicaid may reimburse a surgeon for a surgical service and a PA for the assist-at-surgery service.
- The PA may request authorization for reimbursement for services in excess of the service limitations.
- Medicaid reimbursement for PA services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. PAs are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services. If a PA is salaried by a hospital or other facility, such as a nursing facility that is reimbursed on a cost-related basis, the PA cannot be reimbursed on a fee-for service basis if the costs for the physician assistant's salary are included in the facility's cost report.
- Co-payments for PA services are not allowed for CMS enrollees.
- Specific questions are addressed in the Florida Medicaid Physician Assistant Coverage and Limitations Handbook. More information may be found in the Medicaid Summary of Services booklet.

Physician Extender Participation Status

CMS approved physician extender provider status consists of temporary and active.

- Temporary: Extenders that have met all approval process criteria will be initially approved for a period of one year.
- Active: Extenders who have successfully completed the initial year of CMS participation and have met all re-approval criteria will be subsequently approved for a period of three years.

APPLICATION & APPROVAL PROCESSES

Children's Medical Services (CMS) provider approval process is not a licensure process, but rather a quality assurance process to ensure that participating CMS providers meet established minimum standards deemed necessary for the provision of quality medical services to children, adolescents, and young adults with special healthcare needs.

The CMS provider approval process incorporates standards and recommendations from the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) National Commission for Quality Assurance (NCQA), the American Academy of Pediatrics (AAP), and CMS Medical Directors.

CMS Participation Criteria

Licensed health care professionals wishing to participate in the CMS network of providers must comply with the CMS approval and re-approval processes and criteria. Licensed healthcare professionals must provide information on the following:

- Valid, current State of Florida medical license; and
- Current certifications in area of practice;
- National Provider Identification number;
- Current curriculum vitae; and
- Previous five year work history, explaining any gaps in employment; and
- Current malpractice coverage; and
- Summary of professional liability claim(s) pending or filed against you within the past ten (10) years; and
- Summary of Medicaid and Medicare sanctions within the past ten (10) years; and
- A completed and signed/electronically CMS application and attestation.

Application Process

To assure timely review of provider qualifications in compliance with national quality standards, the entire provider approval process must be completed within 180 days of the signed/electronically submitted application. CMS Central Office Provider Management staff maintains an approval process tracking system to ensure compliance with required timeframes.

Applications may be obtained via: www.cmskidsproviders.com

Once applications have been submitted:

- If there is information missing, applicants will be notified within 15 days of receipt of missing or incomplete application elements.

- The applicant has 30 days from the date of signed/electronically submitted application to provide all missing elements to CMS Central Office. If all elements have not been submitted within the 30-day timeframe, the application will be rejected.

Initial Approval Process

Licensed Healthcare Professionals who meet all CMS participation criteria with no history of liability claims, Medicaid or licensure sanctions/disciplinary action will be approved for CMS Network participation. Those professionals who meet participation criteria but have a history of liability claims, Medicaid or licensure sanctions/disciplinary action will be reviewed by the CMS Healthcare Professional Review Committee. This committee is comprised of a multi-disciplinary team of licensed healthcare professionals. The Deputy Secretary of CMS appoints the Committee members.

The Healthcare Professional Review Committee meets monthly to review completed files and determine provider participation status.

After the initial CMS Program approval, an applicant for some specialty programs such as Early Steps, will have additional program specific requirements that must be met prior to approval for participation in the specialty program.

Participation Status

Active Status

Licensed healthcare professionals approved for active participation status have met all approval process criteria and are placed on the CMS Active Provider Panel for a period of three years. To remain an active provider, licensed healthcare professionals will be required to comply with the CMS re-approval process every three years.

A provider's approval date is the last day of the month in which the final participation status is determined.

Temporary Status

Under special circumstances a provider may be granted Temporary Provider status for a period of up to one year. An example would be a specialty provider in an underserved area of the state who does not currently meet all approval criteria but who has the recommendation of their local CMS Medical Director or Local Early Steps Director. At the end of one year all providers in Temporary status will be reviewed for continued participation.

In special circumstances the CMS Deputy Secretary of Health or the Deputy Secretary's designee may make exceptions to the above approval criteria when it is in the best interest of CMS children or a CMS child might be at risk from the unavailability of a particular specialist.

Non-approved Status

In rare instances, providers may not be approved for participation in the CMS Network. Such instances include, but are not limited to, the following:

- the revocation, suspension or limitation of a provider's healthcare license, medical or clinical privileges at any licensed facility;
- the revocation, suspension or limitation of a provider's right to participate in the Medicaid program;
- findings of professional misconduct or incompetence by any governmental entity or professional organization with competent jurisdiction;
- failure to provide competent service or to comply with CMS patient care standards;
- findings of fraud, embezzlement, acts of moral turpitude, dishonesty, or any other acts which might adversely affect Children's Medical Services, or CMS clients or families;
- legal incompetence, repeated or untreated substance abuse or total and/or permanent incapacity;
- failure to refer within the CMS network of providers (this excludes referrals made in the best interest of the child which have been prior authorized by the local CMS Medical Director);
- failure to comply with CMS Provider approval and re-approval processes and criteria;
- failure to notify CMS of change of address resulting in loss of contact with provider.

Providers will be notified within 15 days of participation status determination.

Renewal Process

Temporary Status

Ninety days before the end of the one-year anniversary of CMS participation approval date, those providers still in temporary status will be reviewed for continued participation as a CMS approved provider.

Active Status

At 33 months from last approval date, CMS Provider Management staff will provide the licensed healthcare professional instructions for reviewing and updating their current provider file.

The entire provider renewal process must be completed within 180 days of the signed re-application and prior to 36 months from provider's last CMS participation approval date. The provider must complete and submit the updated re-approval application within 30 days to maintain active provider status.

Renewal application verifications, review, and approval proceeds as in the initial approval process.

Ad Hoc Reviews

To ensure on-going quality assurance, participating providers may be subject to an Ad Hoc Review triggered by any of the following criteria:

- Complaints, grievances or concerns regarding quality;
- Issues identified during the provider re-approval process;
- Increased incidence of morbidity; and
- Child deaths.
-

Refer to Provider Review Committee Section

Termination

In rare instances, providers may be suspended or terminated from the CMS participation. Such instances include, but are not limited to, the following:

- the revocation, suspension or limitation of a provider's health care license, medical or clinical privileges at any licensed facility, or authorization to dispense or prescribe narcotic drugs;
- the revocation, suspension or limitation of a provider's right to participate in the Medicaid program;
- findings of professional misconduct or incompetence by any governmental entity or professional organization with competent jurisdiction;
- failure to provide competent service or to comply with CMS patient care standards;
- findings of fraud, embezzlement, acts of moral turpitude, dishonesty, or any other acts which might adversely affect Children's Medical Services, or CMS clients or families;
- legal incompetence, repeated or untreated substance abuse or total and/or permanent incapacity;
- failure to refer within the CMS network of providers (this excludes referrals made in the best interest of the child which have been prior authorized by the area CMS Medical Director);
- failure to comply with CMS provider approval and re-approval processes and criteria;
- failure to notify CMS of change of address resulting in loss of contact with provider.

CMS will notify a participating provider upon identifying information that may adversely effect the provider's continued participation with CMS. *Refer to Provider's Rights Section.*

PROVIDER REVIEW COMMITTEE

The Healthcare Professional Review Committee provides Children's Medical Services with technical knowledge reviews of applicants and approved providers to assure the provision of high quality medical services to children with special health care needs. The Healthcare Professional Review Committee is also responsible for helping to ensure that provider rights are protected.

Function

The CMS Healthcare Professional Review Committee will conduct provider reviews providing technical knowledge review particularly for approval and renewal status on exception cases. Exception cases include practitioners who meet established CMS criteria but have potential quality issues identified; including but not limited to: those with sanctions, adverse actions, performance deficits, and paid, pending or settled liability claims.

Upon identification of need to conduct a provider review, the CMS Healthcare Professional Review Committee will convene to review and discuss the provider's file. After receipt and review of all pertinent facts, the committee will determine the provider's CMS participation status.

Committee Composition

The CMS Deputy Secretary of Health appoints the CMS Healthcare Professional Review Committee members to conduct reviews of provider credential files providing technical knowledge reviews that focus on quality of care, particularly for determining participation status on exception cases.

The CMS Healthcare Professional Review Committee consists of a minimum of five Florida licensed health care professionals affiliated with CMS. The Committee's membership is appointed by the CMS Deputy Secretary of Health and is composed of the following:

- at least one practitioner who is a licensed registered nurse; and
- at least one practitioner who is a licensed social worker; and
- at least one practitioner who is a licensed audiologist; and
- at least one practitioner who is a licensed in another healthcare discipline; and
- Committee Chair.
- Ad hoc consultants may be used to review files of specific healthcare disciplines.

Meeting Process

After review of the provider's file, the CMS Healthcare Professional Review Committee will determine the provider's CMS participation status based one of the following:

- *Approved - Active* - Approve provider for participation for three years; or
Temporary – Approve provider for participation for up to one year.
- *Disapproved* - The applicant does not meet stated professional requirements.

- *Pending* - The committee may request additional information or research in order to make a recommendation. In this case, the application will be pending until the next meeting.
- *Suspension* - For substantive information differences or when a CMS patient's health and safety may be in eminent danger an emergency suspension may be invoked pending a hearing process and final resolution.
- *Terminated* - Approved practitioner reviewed for re-approval does not meet the stated professional requirements.

Where a real or perceived conflict of interest may occur, a Committee member shall abstain from voting on any applicant. In situations where the Committee cannot reach decision, the provider's file will be submitted to the CMS Deputy Secretary of Health for participation status determination.

Frequency of Meetings

The CMS Healthcare Professional Review Committee meetings will be scheduled monthly. Additional meetings may be called by the CMS Deputy Secretary of Health on an as needed basis to review quality issues that may adversely effect the provision of quality medical services within the CMS network of providers.

PROVIDER RIGHTS

Children's Medical Services (CMS) Licensed Healthcare Professional Approval Process is not a licensure process, but rather a quality assurance process to ensure that participating CMS Licensed Healthcare Professional meet established minimum standards deemed necessary for the provision of quality medical services to children with special health care needs.

The CMS Licensed Healthcare Professional Approval process focuses on verification of credentials and qualifications. The renewal process focuses on re-verification of credentials and an historical review of the professional's relationship with CMS based on defined criteria for continued participation status.

CMS recognizes a professional's interest in the information being used to determine acceptance into or continued participation in the CMS network of providers. CMS intends to provide a high quality and efficient method of healthcare delivery without actively seeking to impair an individual's right to fully practice his or her profession. Thus, CMS intends to provide fair procedures before excluding or terminating professionals and recognizes the following Provider's Rights.

Right to Review

Providers are notified of their right to review information used to evaluate their approval applications and update incorrect information.

Notification

CMS Deputy Secretary of Health will notify an applicant upon identifying adverse information concerning a provider that varies substantially from the information provided to CMS by the provider. If the applicant fails to provide an explanation or correction within 30 days of receipt of notification, the application is considered withdrawn and the approval process halts.

CMS Deputy Secretary of Health will notify a participating CMS provider upon identifying adverse information concerning the professional that varies substantially from the information provided to CMS by the provider. Failure to provide a plausible and verifiable explanation or correction within 30 days of receipt of notification will be deemed a voluntary termination of participation by the professional.

For substantive information differences or when a CMS client's health and safety may be in eminent danger, an emergency suspension will take place with hearing procedures described below. If the suspension continues more than 14 days, the provider will be given notice and an opportunity for a hearing. The provider's approval will remain suspended pending final resolution. During any suspension period a provider may not provide health care services to CMS clients.

In rare instances, a provider may be suspended or terminated from the CMS Provider Panel. Such instances include, but are not limited to, the following:

- the revocation, suspension or limitation of a professional's health care licensure, medical or clinical privileges at any licensed facility, or authorization to dispense or prescribe narcotic drugs;
- the revocation, suspension or limitation of a professional's right to participate in the Medicaid program;
- findings of professional misconduct or incompetence by any governmental entity or professional organization with competent jurisdiction;
- failure to provide competent service or to comply with CMS patient care standards;
- findings of fraud, embezzlement, acts of moral turpitude, dishonesty, or any other acts which might adversely affect Children's Medical Services or CMS clients or families;
- legal incompetence, repeated or untreated substance abuse or total or permanent incapacity;
- failure to refer within the CMS network of providers (this excludes referrals made in the best interest of the child which have been prior authorized by the local CMS Medical Director);
- failure to comply with CMS approval and re-approval processes and criteria;
- failure to notify CMS of change of address resulting in loss of contact with provider.

CMS will notify a participating provider upon identifying information concerning the provider that indicates the professional has failed to maintain:

- Florida state licensure;
- Appropriate professional certification in practice area.

All new or corrected information submitted by the provider or on the behalf of the provider must be in writing to CMS Central Office, Provider Management Unit.

CMS will notify a participating provider when initiating review action to limit or terminate CMS participation.

Right to Hearing

A provider has a right to request a hearing on a proposed review action. The request must be in writing and made within 30 days of the notification. The Hearing Panel will be comprised of at least the following CMS participating providers:

- one professional of the same specialty;
- the local CMS or Early Steps Medical Director; and
- one member of the CMS Peer Review Committee;

The right to a hearing will be forfeited if the provider fails without good cause to appear.

The provider will be notified no less than 30 days from the date of the hearing. The professional will submit to CMS within ten days prior to the hearing a list of the witnesses.

The provider may have representation, may call, examine, and cross-examine witnesses, and may present evidence and may submit a written statement at the close of the hearing. The provider may have a record made of the proceeding or may obtain copies of such record upon payment of charges associated with the preparation of the record.

The provider may submit a written statement within five days of the close of the hearing.

The provider will receive the written recommendations of the Hearing Panel within 20 days of the hearing adjournment. Within seven days of receipt of the recommendation, the provider will be notified in writing of the CMS Deputy Secretary of Health's decision.

The provider may appeal the CMS Deputy Secretary's decision to the State Surgeon General of the Florida Department of Health (DOH). The Surgeon General's decision is final.

Right to Appeal

The provider may appeal the recommended decision by filing a written appeal within 30 days of notice. The written appeal should demonstrate why the recommended decision is not supported by evidence or is arbitrary and capricious.

The State Surgeon General's decision is final and may not be appealed by either the provider or the Hearing Panel.

In cases in which CMS denies a provider participation approval or terminates a participating provider as a result of conduct based on competence or professional conduct, the CMS Deputy Secretary of Health will report such final actions to the relevant agencies such as, Department of Health Medical Quality Assurance, to the extent required or permitted by law.

Notice of Administrative Rights

To contest an action that adversely affects the provider's ability to participate in Children's Medical Services, provider's have the right to request an administrative hearing under sections 120.569 and 120.57, Florida Statutes. A request for a hearing must be in writing and submitted to CMS Central Office within 21 days of receipt of Notice of Administrative Rights. The request will state the grounds for a hearing, including a statement of all disputed issues of material fact, if any, and why it is felt that the agency's action is improper. Unless waived by all parties, if the provider disputes issues of material fact, section 120.57(1) (formal proceedings) applies. Unless otherwise agreed, section 120.57(2) (informal proceedings) applies in all other cases.

Administrative hearing procedures are governed by Chapter 28-106, Florida Administrative Code. The provider's failure to timely request a hearing shall be deemed a waiver of his or her rights to an administrative hearing and the agency decision shall become final agency action. Mediation is not available. The provider may request judicial review within 30 days of rendition of the final agency action, as prescribed in section 120.68, Florida Statutes, and Florida Rules of

Appellate Procedure, by filing a notice of appeal and appropriate filing fees with the appropriate district court of appeal.

A copy of the notice of appeal must be sent to:

Agency Clerk
Department of Health,
4052 Bald Cypress Way, Bin A02
Tallahassee, FL 32399-1703.

