

**Children's Medical Services**  
Provider Management  
Florida Department of Health

**PROVIDER HANDBOOK**  
**PHYSICIANS & DENTISTS**

2009





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## INTRODUCTION

### Purpose

This handbook was developed to provide CMS physicians and dentists 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 includes 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 are available to physicians 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 and include Early Steps (ES) providers, Florida Newborn Screening Program, Pediatric HIV/AIDS Program, Primary Care Program, Regional Genetics Program, Regional Perinatal Intensive Care (RPICC) and RPICC Obstetrical Satellite Clinic programs.

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 child 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

The CMS Network is a comprehensive, managed system of care for children under age 21 with special medical needs who are enrolled in the CMS Network. The CMS Network also includes Early Steps, Florida's early intervention program, 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, or developmental needs.

### Access to Care

Participating CMS physicians and dentists agree to provide or arrange to provide all medically necessary covered services including emergency services to CMS enrolled children selecting or being assigned to the physician/dentist. The physician/dentist 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. Primary Care Physicians must have the ability to render a clinical decision 24 hours, 7 days a week.

Participating CMS physicians and dentists agree to provide covered services to all assigned CMS children. The physician 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.

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

### Timely Treatment Service Standards

Participating physicians and dentists must agree to provide care in accordance within the following established access standards:

- a. *Routine Well-Child Care* - in which there is no significant medical problem or concern (e.g., child health services per the AAP periodicity schedule and immunizations) must be provided within four weeks of the request for services by the child or the parent/guardian.
- b. *Routine Symptomatic Care* - in which there is a medical concern, but for which there is no urgent or emergency condition, is to be provided within two weeks.
- c. *Urgent Care* - medical care for health problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or do substantially restrict the enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.), must be provided within 24 hours.
- d. *Emergency Care* - those inpatient, outpatient and physician/dental services which are needed immediately because of an injury or unforeseen medical condition and are considered to be necessary to prevent permanent damage to the enrollee's health, in accordance with the prudent layperson's standard, must be provided immediately.

## Authorizations and Referrals

In the event that a physician/dentist is unable or unqualified to provide a covered service to an assigned CMS child, the physician or dentist shall refer only to other CMS participating physicians/dentists unless the required covered service is unavailable through an approved CMS provider.

*Emergency Care* - is to be provided to the child without prior authorization. The physician will notify CMS of all emergency referrals the next business day following the admission.

The physician shall admit CMS children requiring hospitalization or ancillary services only to CMS approved hospitals and facilities unless the necessary services are not available from a participating hospital or facility.

When admitting a CMS child to an out of network physician, hospital or facility, the physician will obtain prior authorization as outlined below, except in the case of an emergency.

### *Out-of-network Services*

- In-state services not available within the CMS Network must be prior approved by the local CMS Medical Director.
- Out-of-state services must be prior approved by the CMS Deputy Secretary of Health.

Approved CMS physicians providing primary care services for CMS Medicaid children must provide and authorize all services identified in the MediPass provider contract.

If the physician/dentist provides services to a CMS child who is enrolled in the Medicaid program, the physician 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.

Physician/dental services that do not have Medicaid rates, under special situations approved by the area Medical Director, will be reimbursed at no more than 60% of the physician's usual and customary fee.

### **Claims Submission**

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

Physicians/dentists 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 physicians/dentists must bill third party payers, including Medicaid, before seeking reimbursement from CMS.

### CMS or Medicaid Funding

When State funding for a service is accepted as payment by a physician or dentist, 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 physician or dentist 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 physician/dentist will maintain client records in a manner that is current, detailed, and organized and permits effective and confidential child care.

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

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

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

CMS client records will be made available to the client or their family upon request. Applicable records request fees may apply for copies of such records.

Physician/dentist 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 physicians and dentists agree to remain licensed to practice medicine in the State of Florida and shall comply with all laws and regulations pertaining to such practice. Physicians and dentists are required to comply with CMS approval and re-approval processes to maintain active CMS physician provider participation status.

## **Allied Health Professionals**

An approved CMS physician must provide primary, secondary and tertiary physician services to CMS enrollees. When an allied health professional / physician extender (ARNP or PA) is employed by the physician and involved in the care of a CMS enrollee, the physician shall include a note in the record that documents that the physician has examined the child, concurs with the findings and is managing the overall care of the child. Payment for services provided to CMS children through this collaborative arrangement is made to the physician.

The physician extender may see CMS enrollees independently of the physician, if they have completed the CMS Physician Extender Approval Process. *Refer to CMS Provider Handbook - Licensed Healthcare Professionals.*

## **Malpractice Coverage**

Physicians and dentists shall maintain the minimum required 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 practice of medicine 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 physician's or dentist's participation in the CMS network on a case by case basis, the physician/dentist 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 physicians and dentists carry appropriate insurance for their own protection (as well as for licensure purposes), in the event that the physician or dentist 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 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 physician/dentist 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 physician/dentist and CMS. In the event that the dispute remains unresolved, the physician or dentist should contact the local CMS Medical Director or Early Steps Director. *Refer to Complaint & Grievance Policy & Procedure Section.*

### **Termination from Participation**

In the event that a physician's or dentist's participation with CMS is terminated by either the provider or by CMS, 90 days notice shall be provided to the other party and to CMS children assigned to or receiving active treatment from the physician or dentist. The 90 days notice is to assure adequate time to transfer care of the child to another CMS 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 local 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>

## SPECIALTY PROGRAM PROVISIONS - PHYSICIANS

In addition to the information outlined in the General Provisions section, physicians participating in some CMS specialty programs will be required to meet and comply with additional program specific criteria.

### **CHILD PROTECTION TEAM**

In addition to the information outlined in the General Provisions - CMS Network section, physicians participating in the Child Protection Team (CPT) program will meet and comply with the following CPT specific criteria and requirements.

CPT supports the Department of Children and Families and designated sheriff's offices in services to children who are reported to the child abuse hotline. The Child Protection Teams provide screening of all hotline reports to identify children mandated by law to be referred to a child protection team for assessment. The teams provide child unique medically directed multidisciplinary team assessments and make recommendations to the Department of Children and Families that assess risk to the child for the objective of preventing further abuse.

### **CPT Physician and Medical Director Standards**

All physicians providing direct medical services or medical oversight functions for a child protection team must be a member of the CMS Physician Panel, and are therefore subject to the requirements and process outlined in this handbook for attaining active CMS physician status.

The CPT Statewide Medical Director, Associate Medical Director, and the CPT Medical Director must be available seven days a week, 24 hours a day, or have arranged coverage by another CPT Medical Director.

#### Child Protection Team Medical Director

CMS physicians desiring to be a Child Protection Team Medical Director must be an approved CMS physician, must be recommended by the designated statewide Child Protection Team Medical Director, be board-certified in pediatrics, have demonstrated interest in and received training in child abuse and neglect diagnosis, maintain direct medical skills in medical evaluations of child abuse and be willing, as directed by CMS, to continue child abuse and neglect in-service training. Under special or extenuating circumstances, the Deputy Secretary of CMS may waive the provision of board certification in pediatrics for a specified period of time.

By law, appointment to the position of a CPT Medical Director requires the concurrence of the State Surgeon General of the Florida Department of Health and the Secretary of the Florida Department of Children and Families.

#### Statewide CPT Medical Director

The above standards also apply to the position of statewide CPT Medical Director.

## **CPT Statewide Medical Oversight**

The department contracts for the statewide medical oversight of the Child Protection Team Program and designates a statewide Child Protection Team(CPT) Medical Director to oversee the program. Functions of the statewide director include the evaluation of services provided by individually appointed team medical directors. The statewide CPT Medical Director provides these oversight functions under the direction of the Children's Medical Services (CMS) Deputy Secretary of Health.

## **CPT Local Area Medical Services & Oversight**

### CPT Medical Oversight

While working functionally under the statewide Medical Director, individual CPT Medical Directors are employed in Other Personal Services (OPS) status by the department, and are under the overall direction of the CMS Deputy Secretary of Health. In addition to other duties, team CPT Medical Directors are responsible for supervision and review of medical personnel work providing medical evaluation services for a team.

### CPT Medical Evaluation Services

Medical services for a team are provided by CMS physician providers and other licensed medical personnel. Services can include abuse report screening, medical evaluation of or medical consultation for a specific child. Remuneration for these services is provided by the administering agency of the local team.

### Local CPT Administering Agencies

The department contracts with a variety of non-profit and public agencies to administer team services throughout the state. These agencies provide and purchase medical, legal, and other professional services as needed to provide team services in their designated local areas. CMS physician direct medical evaluation services and travel expenses related to CPT functions are paid by the local administering agency.

### Child Protection Team Program Handbook

For more information on the Child Protection Team Program, please refer to the CPT Program Handbook. This handbook may be obtained from your local area Team Coordinator.

## **CPT 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 physician and CMS. In the event that the dispute remains unresolved, the CPT physician should contact the appropriate level of the following three positions: the team CPT Medical Director, the statewide CPT Medical Director, or the CMS Deputy Secretary of Health.

## **EARLY STEPS**

In addition to the information outlined in the General Provisions section, physicians 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. Sixteen 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 Physician and Medical Directors Standards**

All Early Steps Medical Directors and physicians providing direct medical services or medical oversight functions for children enrolled in Early Steps must be a member of the CMS Physician Panel, and are therefore subject to the requirements and process outlined in this handbook for attaining active CMS participation status.

### **Access to Care**

Participating CMS Early Steps physicians agree to provide covered services to all assigned Early Steps children. The physician will neither differentiate nor discriminate in the treatment of or in the quality of medical services delivered to Early Steps children on the basis of race, color, national origin, religion, disability or gender.

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

Participating physicians must agree to provide care in accordance with the following Part C of the Individuals with Disabilities Education Act (IDEA) service definitions:

- *Medical Services* means services provided by a licensed physician for diagnostic or evaluation purposes to determine a child's developmental status and need for early intervention services.

- *Health Services* means services necessary to enable a child to benefit from the other early intervention services during the time that the child is receiving the other early intervention services. 20 U.S.C.1432(4)(E)

### **Authorizations/Referrals**

Approved CMS Early Steps physicians will provide medical/health services as authorized by the Local Early Steps (LES) offices and through the child's Individualized Family Support Plan (IFSP).

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

### **Reimbursement**

The Local Early Steps (LES) offices or approved CMS Early Steps physician must bill public or private sources or third party payer for direct services for eligible children and their families. The LES office or physician shall not collect Part C funds for direct services unless third party collection is denied by the third party payer, and written evidence of denial is on file with the physician. The physician will be reimbursed in accordance with contract specifications. The order in which funding for service is to be sought is as follows:

1. Commercial Insurance
2. Medicaid
3. Community Funding
4. Other State Program Funds
5. Other Federal Program Funds
6. Part C Funds

### **Claims Submission**

Physicians should submit claims for payment within 60 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 physicians 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 physician, 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.

### **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 local Early Steps Offices issues, please contact the CMS Early Steps State Office.

## **REGIONAL PERINATAL INTENSIVE CARE CENTERS PROGRAM PROVISIONS**

In addition to the information outlined in the General Provisions section, physicians participating in the Regional Perinatal Intensive Care Centers (RPICC) program will meet and comply with the following RPICC specific criteria and requirements.

RPICC serves indigent, high risk pregnant women and low birth weight/sick newborns at 11 sites in the State. The RPICC Obstetrical Satellite Clinic Program provides outpatient prenatal care services to high risk pregnant women in community settings throughout the state.

### **RPICC Physician and Medical Director Standards**

All RPICC Medical Directors and physicians providing direct medical services or medical oversight functions for a RPICC center or OB Satellite clinic must be a member of the CMS Physician Panel, and are therefore subject to the requirements and process outlined in this handbook for attaining active CMS physician status.

#### RPICC Neonatal Medical Director

Must be board certified in Neonatology.

#### RPICC Neonatologist

Must be board certified in Neonatology or eligible to take the written Neonatology examination and must demonstrate an active, continuing pursuit of board certification at the time of CMS re-approval review.

#### RPICC Obstetrical Medical Director

Must be board certified in Obstetrics-Gynecology or has passed the written OB-GYN exam and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or has passed the written MFM exam and is an active candidate to take the oral exam.

#### RPICC Obstetrician

Must be board certified in Obstetrics or must have passed the written examination of the OB/GYN board certification process and they must demonstrate an active, continuing pursuit of board certification at the time of CMS re-approval review.

#### Maternal Fetal Medicine Physician

Must be board certified in Obstetrics-Gynecology or has passed the written OB-GYN exam and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or has passed the written MFM exam and is an active candidate to take the oral exam.

#### RPICC Obstetric Satellite Clinic Physician

Must be board certified in Obstetrics-Gynecology or has passed the written OB-GYN exam and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or has passed the written MFM exam and is an active candidate to take the oral exam.

## **RPICC Reimbursement**

### Medicaid RPICC Clients

Payment for obstetrical outpatient services should be billed using Medicaid fee-for-service reimbursement.

Payment for neonatal and obstetrical inpatient services is based on one of the diagnosis-related groups for obstetrics and neonates listed below:

- OBCG - obstetrical care group
- NCG – neonatal care group

The RPICC payment is a global fee that covers all physician services or procedures performed by the RPICC provider group. All other Medicaid fee-for-service reimbursement must be billed through the non-RPICC provider group number.

RPICC services cannot be reimbursed by Medicaid for recipients who have other health insurance.

Reimbursement for RPICC services to a Medicaid HMO recipient must be negotiated between the RPICC provider group and the respective HMO.

Providers can be reimbursed only for emergency services provided to aliens who are not eligible for full Medicaid benefits due to their alien status.

Providers cannot receive reimbursement through the RPICC program for Medically-Needy recipients. Medically Needy recipients are not financially eligible for the RPICC Program.

## **RPICC Claims Submission**

### Physician Services

RPICC billing for Medicaid reimbursement of OBCG or NCG payments is done through the RPICC Data System except for the following exceptions, which must be billed on paper claims:

- Neonatal claims with multiple RPICC facility transfers.
- Obstetrical claims with multiple antepartum hospitalizations, sterilizations, or hysterectomies.

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

### Allied Health Professionals

Outpatient services and nurse midwife services including those provided under the personal supervision of the RPICC physician are reimbursed using the Medicaid fee-for-service methodology.

### **RPICC Participation Termination**

In the event that a physician's participation with CMS is terminated by the physician, the RPICC Program or by CMS Program, notice shall be provided to Medicaid to terminate the physician's participation with the RPICC provider group.

A RPICC neonatal physician may be terminated from participation in the RPICC Program upon failure to demonstrate an active, continuing pursuit of board certification as demonstrated by failure to pass the neonatal boards or failure to take the written neonatal examination at the first opportunity after completion of training in an ACGME approved Neonatal-Perinatal Medicine Fellowship Training Program.

A RPICC obstetric physician may be terminated from participation in the RPICC Program upon failure to demonstrate an active, continuing pursuit of board certification as demonstrated by failure to pass the Obstetrics-Gynecology Boards.

## **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 physicians and dentists meet established minimum standards deemed necessary for the provision of quality medical services to children, youth, and young adults with special health care needs.

The CMS provider approval process incorporates standards 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 recommendations CMS Medical Directors.

### **CMS Participation Criteria**

Physicians and dentists wishing to participate in the CMS network of providers must comply with the CMS approval and renewal processes and criteria. Physicians and dentists must provide information on the following:

- Valid, current State of Florida medical license; and
- Current board certification or actively in the process of obtaining board certification\* in area of practice;
- Current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certification; and
- National Provider Identification number; and
- Current curriculum vitae; and
- Previous five year work history, explaining any gaps in employment; and
- Current malpractice coverage or bond that complies with the physician's relevant practice act in the Florida Statutes; and
- Summary of professional liability claim(s) pending or filed against you within the past ten (10) years. Include date of occurrence, brief summary of events, present status of claim, and amount paid, if applicable; and
- Summary of Medicaid and Medicare sanctions within the past ten (10) years; and
- Current, full active admitting privileges at a CMS approved hospital; or Letter of Transfer Agreement with a CMS approved physician in good standing who has current admitting privileges at a CMS approved hospital (Physicians only); and
- A completed and signed/electronically submitted CMS application and attestation.

Board Certification - Effective October 1, 2001, CMS will require all participating physicians to be board certified in their area of practice.

- Board Certifications will be verified from one of the following sources:
  - American Board of Medical Specialties (ABMS)
  - Copy of Board Certificate from the appropriate specialty board
- Non-board certified applicants who meet requirements for board certification examination may be approved for active status pending completion of board certification. The provider must achieve board certification before their three (3) year re-approval date.
- Specialty physician providers who have not yet obtained their specialty board certification must be certified by their primary board, when applicable, before they will be eligible to provide specialty services to CMS children.
  - Non-board certified specialty physicians must achieve specialty board certification before their three-year re-approval date to continue to provide specialty services to CMS children, unless certification process is a multiphase process.
  - For those specialties that have a multiphase certification process, the physician must have passed the first step of the board certification process and they must demonstrate an active, continuing pursuit of board certification at the time of their re-approval review to continue to provide specialty services to CMS children.
- Subspecialty physicians not providing primary care services will not be required to maintain active certification of their primary board.
- Physicians approved for CMS participation before October 1, 1998 were exempt from the board certification requirement and Grandfathered for board certification.

Under special circumstances and when in the best interests of the CMS participants the CMS Deputy Secretary of Health may grant, upon recommendation from CMS Medical Director, CMS approved provider status to any physician or dentist licensed in the State of Florida.

### **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 submitted/signed application. CMS Central Office Provider Management staff maintains an approval process tracking system to ensure compliance with required timeframes.

Applications may be accessed and submitted via: [www.cmskidsproviders.com](http://www.cmskidsproviders.com)

Once application have been submitted:

- If there is information missing, CMS Provider Management staff notifies the applicant within 15 days of receipt of missing or incomplete application elements.

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

CMS physician/dentist credentials verifications will be performed using on-line sources with the exception of the following:

- Hospital privileges will be verified by CMS via mailed confirmation from the hospital, or Letter of Transfer Agreement will be verified via mailed or faxed confirmation from CMS physician participating in the transfer agreement; and
- Verification of recommendation by applicable CMS program Medical Director via notification and confirmation letter.

### **Initial Approval Process**

Physicians and dentists 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 Physician Review Committee.

The Physician Review Committee meets monthly to review completed files and recommend individual provider CMS participation status to the CMS Deputy Secretary of Health. The CMS Deputy Secretary of Health makes the final CMS participation status determination.

### **Participation Status**

A physician's or dentist's provider approval date is the date of the of the CMS Deputy Secretary's notification to the provider of their CMS participation status.

#### Active Status

Physicians and dentists approved for active provider 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, providers will be required to comply with the CMS renewal process every three years.

#### Physician Emeritus Designation

In order to provide CMS with the continued medical and historical expertise of retired CMS approved physician providers, an additional physician participation status is recognized. A designation as Physician Emeritus allows retired physicians to serve in an administrative only capacity for various CMS programs.

Physicians meeting all of the following criteria may be conferred Physician Emeritus status by the CMS Deputy Secretary of Health:

- Ten (10) years of experience as a CMS physician provider
- Retired in good standing from active practice

- Recommendation by a CMS Medical Director
- Valid, active or inactive State of Florida medical license

Prior to consideration, a physician candidate must submit the following items:

- Current curriculum vitae;
- Previous five year work history, explaining any gaps in employment;
- Summary of professional liability claim(s) pending or filed against the applicant within the previous ten (10) years, including date of occurrence, brief summary of events, current status of claim, and amount paid, if applicable.
- Summary of Medicaid and Medicare sanctions within the previous ten (10) years.
- Completed and signed CMS attestation.

### Temporary Status

Under special circumstances a physician or dentist may be granted Temporary Provider status for a period of up to one year. An example would be a specialty physician in an underserved area of the state who is not board certified in pediatrics or their subspecialty and who has the recommendation of their regional / area CMS medical director. At the end of one year all providers in Temporary status will be reviewed for continued participation as a CMS approved provider.

In special circumstances or emergency situations the CMS Deputy Secretary of Health may make exceptions to the 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.

### Emergency Approval

Upon request by the local CMS area office Medical Director, emergency provider participation approval may be granted by the CMS Deputy Secretary of Health to provide continuity of care or access to care to CMS enrollees. Emergency approval is time limited, not to exceed 90 days, pending submission of a completed CMS provider application.

### Not Approved

In rare instances, providers may not be approved for participation 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, 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 children 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 renewal processes and criteria;
- failure to notify CMS of change of address resulting in loss of contact with provider.

Notification of provider status will be mailed to applicant within fifteen (15) days of status determination.

### **Renewal Process**

#### Temporary Status

Ninety days before the end of the one-year anniversary of CMS Provider 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 physicians and dentists with instructions for reviewing and updating their current provider file.

The physician/dentist must complete and return to CMS the renewal application within 30 days to maintain active provider status.

The entire provider renewal process must be completed within 180 days of the signed/electronically submitted renewal application and prior to the expiration date for the provider's CMS approval.

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

### **Interim Reviews**

To ensure on-going quality assurance, participating providers may be subject to interim reviews through the following mechanisms:

- Practice Site Reviews, conducted as part of the initial approval process for CMS primary care physicians; or
- Ad Hoc Reviews, as determined by the CMS Deputy Secretary of Health triggered by any of the following criteria:
  - Questions concerning medical decision making;
  - Complaints, grievances or concerns regarding quality;

- Issues identified during the provider renewal process;
- Increased incidence of morbidity; and
- Child deaths.

### **Termination**

In rare instances, providers 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 physician's or dentists healthcare 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 children 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 renewal processes and criteria;
- failure to notify CMS of change of address resulting in loss of contact with provider.

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

## **PHYSICIAN REVIEW COMMITTEE**

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

### **Structure**

The CMS Deputy Secretary of Health is directly responsible for the CMS physician and dentist approval processes and the Physician Review Committee.

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

Exception cases include providers 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. The committee will discuss each individual case and present their recommendations to the CMS Deputy Secretary of Health at regularly scheduled committee meetings. The Deputy Secretary makes the final decision to approve, disapprove or terminate a physician's or dentist's CMS participation status.

### **Committee Composition**

The Physician Review Committee consists of a minimum of three Florida licensed, board certified pediatric physician providers actively participating in CMS and routinely providing care to CMS children. The Committee's members are appointed by the CMS Deputy Secretary of Health and are composed of the following:

- at least one practitioner who is a primary care physician board certified in Pediatrics; and
- at least one practitioner who is a board certified pediatric sub-specialty provider; and
- one Committee Chair;
- ad hoc consultants may be used to review files of subspecialty providers.

CMS Provider Management staff facilitate the Physician Review Committee's work and attend Committee meetings to represent CMS Central Office include the CMS Provider Management Unit Director and the Bureau Chief for CMS Network Operations.

### **Membership Terms**

Each Physician Review Committee member serves a three-year term and may be reappointed for a consecutive three year term. The Committee uses a staggered rotation process, rotating members off each year to provide Committee continuity. After a one-year hiatus, a member may serve another three-year term. Due to the need to approve physician participation in a timely manner, a Committee member who does not participate in a minimum of 75% of scheduled meetings will be removed from Committee participation.

## Function

The Physician Review Committee will conduct physician and dentist credential reviews providing technical knowledge review for approval and renewal status on exception cases. The Committee will receive and review:

- A list of the names of providers who meet established CMS provider criteria and have no potential quality issues identified. The Committee may choose to review the credentials of those that meet criteria; and
- The credentials of providers who do not meet established CMS criteria and/or have potential quality issues identified. Exception cases include, but are not limited to those with sanctions, adverse actions, performance deficits, and paid, pending or settled lawsuits or lack board certification.

The Physician Review Committee will recommend approval, disapproval, suspension or termination to the CMS Deputy Secretary of Health. The recommendations will be based on established CMS requirements for CMS participation and applicable standards of care, as well as reasons for termination listed in the CMS Provider Handbook Physicians and Dentists. The CMS Deputy Secretary of Health will make final participation status determination.

## Meeting Process

The Physician Review Committee will be provided the meeting agenda. The agenda will list all applicants and providers due for approval, renewal or other review by region and specialty. To facilitate a quality review process, the physicians and dentists will be listed on the agenda and in minutes in a blind format. The agenda will identify and describe any approval process element defined as an exception. Complete files will be available to the Committee for review and discussion.

Following Committee review and thoughtful consideration of a provider's credentials, a vote will be taken recommending one of the following participation statuses:

- *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 child's health and safety may be in eminent danger an emergency suspension may be invoked pending a hearing process and final resolution.
- *Terminated* - Approved provider reviewed for renewal 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 Physician Review Committee cannot reach decision, the CMS Deputy Secretary of Health may elect to make a decision without a recommendation from the committee.

### **Frequency of Meetings**

Physician Review Committee meetings will be scheduled monthly. The meetings may be conducted via conference call with necessary review information supplied to each member electronically prior to the meeting.

Additional meetings may be called by the CMS Deputy Secretary of Health on an as needed basis to emergently 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) 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 and dental services to children with special health care needs.

The CMS provider approval process focuses on verification of credentials and qualifications. The renewal process focuses on re-verification of credentials and an historical review of provider's relationship with CMS based on defined criteria for continued participation status.

CMS recognizes a physician's or dentist'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 providers and recognizes the following Provider Rights.

### Right to Review

Physicians and dentists 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 the provider that varies substantially from the information provided to CMS by the physician or dentist. 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 physician or dentist upon identifying adverse information concerning the provider that varies substantially from the information provided to CMS by the physician. 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 provider.

For substantive information differences or when a CMS child'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 fourteen days, the physician or dentist will be provided with notice and an opportunity for a hearing. Provider approval will remain suspended pending final resolution. During any suspension period a physician or dentist may not provide healthcare services to CMS children.

In rare instances, physicians or dentists 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 provider's healthcare 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 children 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 renewal 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 physician that indicates the physician or dentist has failed to maintain:

- Florida state licensure with adequate professional liability insurance or bond, as required by state law;
- Appropriate board certification in practice area;
- Hospital privileges, or Letter of Transfer agreement with a approved CMS physician (physicians only).

All new or corrected information submitted by the provider or on the behalf of the provider must be in writing to CMS.

CMS will notify a participating physician or dentist when initiating Physician Review Committee action to limit or terminate participation.

### **Right to Hearing**

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

- one provider of the same specialty;
- the local CMS Medical Director; and
- one member of the Physician Review Committee;

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

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

The physician/dentist 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 physician/dentist 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 physician/dentist may submit a written statement within five days of the close of the hearing.

The physician/dentist 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 physician/dentist 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 physician may appeal the recommended decision by filing a written appeal within thirty 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 physician or the Physician Review Committee.

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

### **Notice of Administrative Rights**

To contest an action that adversely effects the provider's ability to participate in Children's Medical Services, providers 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 HCMS 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.

