

# MEDIPASS PROVIDER ENROLLMENT CHECKLIST

To ensure that all materials necessary for enrollment/re-enrollment in MediPass are received, please be sure to send the following items to your area office:

- \_\_\_ Completed Agreement for Participation in MediPass, Attachment I (pg. 1)
- \_\_\_ Completed MediPass Provider Enrollment Form, Attachment II (pg. 2 and 3)
- \_\_\_ Submit most recent hospital appointment/reappointment letter verifying current hospital privileges of admitting physician.
- \_\_\_ “Verification of Hospital Privileges” form, Attachment III, must be completed if a current hospital appointment or reappointment letter is not obtainable, or if another provider admits for you. (pg. 4)
- \_\_\_ A copy of your current DEA certificate; if applicable.
- \_\_\_ A copy of your current curriculum vitae which includes a five year work history.

**NOTE: AFTER COMPLETING THE ABOVE, PLEASE RETURN ONLY THOSE PAGES TO THE AREA OFFICE. RETAIN THE REST OF THIS PACKET FOR YOUR RECORDS, AS THIS IS YOUR AGREEMENT. THESE ARE THE STANDARDS, POLICIES AND PROCEDURES FOR YOU TO FOLLOW FOR COMPLIANCE WITH MEDIPASS.**

**AGREEMENT FOR PARTICIPATION IN MEDIPASS  
TABLE OF CONTENTS**

**Enrollment/Re-enrollment**

1. Agreement for Participation in MediPass Attachment I ..... 1  
2. MediPass Provider Enrollment Form MD/DOs Attachment II ..... 2  
3. MediPass Provider Enrollment Form ARNP/PAs Attachment II ..... 3  
4. Verification of Hospital Privileges Form Attachment III ..... 4  
5. Instructions for Completing Enrollment Form ..... 5

**MediPass General Statement of Intent ..... 7**

**MediPass General Statement of Purpose ..... 7**

**Services To Be Managed**

1. General Services ..... 8  
2. Child Health Check-up (formerly EPSDT Screening) ..... 8  
3. Childhood Immunizations ..... 9  
4. Adult Health Screening ..... 10  
5. Obstetrical Services ..... 10  
6. Specialized Services ..... 11  
7. Excluded Services ..... 12

**Manner of Service Provision**

1. Medical Records ..... 12  
2. Tuberculosis Reporting ..... 13  
3. Access to Care ..... 13  
4. Authorizations and Referrals ..... 14  
5. Patient Acceptance ..... 15  
6. ARNPs and PAs ..... 16  
7. MediPass Training ..... 16  
8. Disease Management Initiatives ..... 16  
9. Pre-Paid Mental Health Initiative ..... 17  
10. MediPass Change of Status ..... 17  
11. Change of Ownership ..... 17  
12. Hospital Privileges ..... 17  
13. Primary Care Services Billing Number ..... 18  
14. Hospital Affiliated MediPass Providers ..... 18  
15. Limits on Number of Patients ..... 18  
16. Patient Choice of MediPass Provider ..... 19  
17. Patient Disenrollment by Provider ..... 19  
18. Patient Enrollment/Disenrollment Effective Date ..... 19  
19. Participation of Employees of Group Providers ..... 20

20. Provision of Patient Data and Reports .....	20
21. Provider Service Network.....	20
22. Minority Physician Network Program and Pediatric Emergency Room Diversion Program.....	21
23. Exclusive Provider Organization (EPO).....	21

**Enrollment**

1. Marketing.....	21
2. Outreach.....	21

**Method of Payment**

1. Management Fee.....	22
2. Service Reimbursement .....	22

**Special Provisions**

1. Termination (General) .....	22
2. Termination (Sole, Group or Public Funded Provider) .....	22
3. Termination of Participating Providers in a Group.....	23
4. Provider Enrollment.....	23
5. Credentialing Standards .....	23
6. Recredentialing Standards .....	25
7. Quality of Care Standards.....	25
8. Sanctions.....	27
9. Definitions.....	31

Exhibit A: MediPass Provider Credentialing Site Survey Report

**ATTACHMENT I**  
**AGREEMENT FOR PARTICIPATION IN MEDIPASS**  
**(Provider Enrollment Section)**

Please complete and return this section of the Agreement for Participation in MediPass, including the MediPass Provider Enrollment Form (Attachment II) to the MediPass Unit at your local Medicaid Office.

\_\_\_\_\_  
**PRACTICE NAME/DBA Name**

\_\_\_\_\_  
**MEDICAID PROVIDER NUMBER**

\_\_\_\_\_  
**NPI NUMBER**

\_\_\_\_\_  
**LOCATION ADDRESS**

\_\_\_\_\_  
**CITY**

\_\_\_\_\_  
**STATE**

\_\_\_\_\_  
**ZIP CODE**

\_\_\_\_\_  
**MAILING ADDRESS**

\_\_\_\_\_  
**CITY**

\_\_\_\_\_  
**STATE**

\_\_\_\_\_  
**ZIP CODE**

Our primary care area of practice is **(LIST ONLY ONE)**: \_\_\_\_\_.  
(general practice, family practice, pediatrics, internal medicine, obstetrics, gynecology). CHDs and FQHCs should list general practice as area of practice.

The number of primary care physician(s) who wish to enroll in MediPass is: \_\_\_\_\_.

The number of Advanced Registered Nurse Practitioner(s) who wish to enroll in MediPass is: \_\_\_\_\_.

The number of Physician Assistant(s) who wish to enroll in MediPass is: \_\_\_\_\_.

The total number of MediPass patients this practice agrees to accept is: \_\_\_\_\_. (Should not exceed Item 16 on Enrollment Form, Attachment II, page 2). Minimum enrollment requirement of 50 patients.

This practice prescribes controlled substances. YES \_\_\_\_\_ NO \_\_\_\_\_

This practice would like this Agreement to become effective and remain in effect until amended or terminated pursuant to the terms of this Agreement.

I attest that this practice has an active patient load of no more than 3,000 patients per primary care provider of all populations: MediPass, Medicaid Fee-for-Service, Medicaid Prepaid Health Plan (PHP), Health Maintenance Organization (HMO), Medicare or commercial entity. An active patient is one that is seen by the same primary care physician, or by a physician assistant or advanced registered nurse practitioner under the supervision of the primary care physician, at least three times within a calendar year.

Unless separately disclosed in a signed statement, I further attest that no provider in this practice is currently under investigation or has ever been subject to disciplinary or corrective action such as admonition, reprimand, censure, probation, suspension, termination, revocation or reduction of privileges by any medical staff, professional organization, or licensing organization, Medicaid or Medicare fines, sanctions or settlements imposed.

I warrant that the information provided herein, including the answers to the preceding questions, are true and correct to the best knowledge and belief of the practice. I further warrant that the information provided on the MediPass enrollment form is true and correct to the best knowledge and belief of the practice.

I understand that any information I attest to herein and on the MediPass enrollment form may be used to update information in my Medicaid provider file.

I attest to receipt of the MediPass Agreement and understand its contents.

I attest that I have read the Medicaid Provider Handbooks appropriate for my practice.

I hereby authorize MediPass to credential the qualifications of the practitioners in this practice and verify the information provided herein.

\_\_\_\_\_  
Name of Provider or Authorized agent and title  
(print)

\_\_\_\_\_  
Contact Person Name and Title

\_\_\_\_\_  
Signature of Person listed above

\_\_\_\_\_  
Contact Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact Telephone Number

**ATTACHMENT II  
MEDIPASS PROVIDER ENROLLMENT FORM**

(Please refer to the instruction sheet as you complete this form. Make additional copies as needed.)

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_  
 Practice Name/DBA Name Medicaid Practice Provider # NPI # Practice Telephone, Fax, E-Mail Address

(5) \_\_\_\_\_ (6) \_\_\_\_\_ (7) \_\_\_\_\_  
 Foreign Language(s) Spoken Patient Limitations (if any) Type of 24 Hour Coverage

**PROVIDERS**

(8) Name (Followed by Degree) (Print or Type)	(9) DOB	(10) MEDICAID PROVIDER #	(11) NPI #	(12) ** SOCIAL SECURITY #	(13) *** SIGNATURE	(14) DATE
WKLY HOURS		(15)	(16)	*750 (ARNP/PA) or		(17)
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)		=
WKLY HOURS		(15)	(16)	*750 (ARNP/PA) or		(17)
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)		=
WKLY HOURS		(15)	(16)	*750 (ARNP/PA) or		(17)
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)		=
WKLY HOURS		(15)	(16)	*750 (ARNP/PA) or		(17)
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)		=
WKLY HOURS		(15)	(16)	*750 (ARNP/PA) or		(17)
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)		=

\* Max Pt. Load for M.D.s and D.O.s =1500  
 Max Pt. Load for ARNPs and PAs =750  
 See Next Page for ARNP's and PA's servicing as physician extenders

(18) Maximum Patient Enrollment

**Total of Column 17**

\*\* Disclosure of your social security account number is voluntary. The Agency for Health Care Administration shall use such information for purposes of internal identification.

\*\*\* By signing above: I attest to my participation in the practice for the hours allotted.

(19) Number of Patients Desired. **Must be Less than or equal to the Max Allowed in item 18**

ATTACHMENT II

**MEDIPASS PHYSICIAN EXTENDER ENROLLMENT FORM**  
**ARNP'S AND PA'S**

(Please refer to the instruction sheet as you complete this form. Make additional copies as needed.)

(20) \_\_\_\_\_ (21) \_\_\_\_\_ (22) \_\_\_\_\_ (23) \_\_\_\_\_  
 Practice Name/DBA Name Medicaid Practice Provider # NPI # Location Address

**EXTENDERS**

(24) Name (Followed by Degree) (Print or Type)	(25) DOB	(26) MEDICAID PROVIDER #	(27) NPI #	(28) ** SOCIAL SECURITY #	(29) *** SIGNATURE	(30) DATE
WKLY HOURS		(31)	(32)	*750 (ARNP/PA) or	(33)	
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)	=	
WKLY HOURS		(31)	(32)	*750 (ARNP/PA) or	(33)	
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)	=	
WKLY HOURS		(31)	(32)	*750 (ARNP/PA) or	(33)	
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)	=	
WKLY HOURS		(31)	(32)	*750 (ARNP/PA) or	(33)	
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)	=	
WKLY HOURS		(31)	(32)	*750 (ARNP/PA) or	(33)	
0-40		_____ Divided by 40 = _____	X _____	1500 (MD/DO)	=	

\* Max Pt. Load for M.D.'s and D.O.'s = 1500  
 Max Pt. Load for ARNPs and PAs = 750.

\*\* Disclosure of your social security account number is voluntary.  
 The Agency for Health Care Administration shall use such information for purposes of internal identification.

\*\*\* By signing above: I attest to my participation in the practice for the hours allotted.

(34) Maximum Patient Enrollment

**Total of Column 33**

(35) Number of Patients Desired. **Must be Less than or equal to the Max Allowed in item 30**

**(36) GRAND TOTAL DESIRED**  
 (TOTAL OF ITEMS 19 & 35)

ATTACHMENT III

VERIFICATION OF HOSPITAL PRIVILEGES

Section I of this form should be completed by primary care providers wishing to enroll in MediPass who have admitting privileges. Those providers who do not have admitting privileges at the hospital designated as the primary admitting facility must ensure that Section II is properly completed and Section II should be executed by the provider with whom the primary care provider has entered into an arrangement for hospital coverage. The form should be signed only by the provider with admitting privileges.

SECTION I: TO BE COMPLETED BY PROVIDERS WITH ADMITTING PRIVILEGES WISHING TO ENROLL IN MEDIPASS. (Please sign at the bottom to indicate that you authorize MediPass to verify privileges with the admitting facility named)

NAME OF MEDIPASS APPLICANT: \_\_\_\_\_
MEDICAID PROVIDER NUMBER: \_\_\_\_\_
NPI NUMBER: \_\_\_\_\_
NAME OF ADMITTING FACILITY: \_\_\_\_\_
ADDRESS OF FACILITY: \_\_\_\_\_

SECTION II: TO BE COMPLETED BY PROVIDERS NOT HAVING ADMITTING PRIVILEGES AND THE PROVIDER (MEDICAID or MEDIPASS PHYSICIAN) HANDLING INPATIENT COVERAGE

NAME OF MEDIPASS APPLICANT: \_\_\_\_\_
MEDICAID PROVIDER NUMBER: \_\_\_\_\_
NPI NUMBER: \_\_\_\_\_
NAME OF ADMITTING PROVIDER: \_\_\_\_\_
MEDICAID NUMBER OF ADMITTING PROVIDER: \_\_\_\_\_
NAME OF ADMITTING FACILITY: \_\_\_\_\_
ADDRESS OF FACILITY: \_\_\_\_\_

The signature below indicates agreement to the following terms:

- Responsibility for inpatient admissions will be assumed by the admitting provider physician
• MediPass is hereby authorized to verify clinical privileges of the provider listed below
• The provider listed above authorizes and releases from liability all third parties furnishing information to MediPass, for their acts performed in good faith and without malice in connection with the gathering and exchange of information with respect to clinical privileges
• The providers listed above assume the obligation to notify the MediPass program if this arrangement between providers is in any way changed or terminated

NAME OF ADMITTING PHYSICIAN (PRINTED/TYPED)

SIGNATURE

DATE

## **INSTRUCTIONS FOR COMPLETION OF MEDIPASS PROVIDER ENROLLMENT FORM**

Completion of Attachment II (MediPass Provider Enrollment Form) will determine the number of MediPass clients your practice is eligible and willing to serve.

1. Practice Name- Enter the name associated with the Medicaid provider number for that location, as well as DBA (doing business as) names for this location.
2. Medicaid Provider Number- Enter the Medicaid provider number for that location. If there is more than one practice each MUST have its own Medicaid provider number. This is accomplished by replacing the last 2 digits of your current Medicaid number with a new 2 digit “locator number” for each additional practice location. To obtain a locator number, contact Medicaid’s fiscal agent. County Health Departments request locator number(s) 91-98 by contacting Medicaid’s fiscal agent
3. NPI Number- Enter the National Provider Identifier number for that location.
4. Practice Telephone- Enter the practice location telephone number. This must be a number beneficiaries can call to access medical care on a 24-hour basis.
5. Foreign Languages Spoken- Enter languages spoken in addition to English.
6. Patient Limitations- Enter limitations for your practice, if any, i.e.: “ages 5 and up”, “females only”, “adults only”, etc.
7. Type of 24-hour Coverage- Explain the type of 24-hour coverage your office provides e.g.: answering service, call forwarding, physician on-call coverage or other customary means. Your method of 24-hour coverage must be accessible using the office daytime telephone number. The chosen method of 24-hour coverage must connect the caller to someone who can either render a clinical decision or reach a MediPass provider for a clinical decision.
8. Enter the name of each person in the practice that will participate in MediPass followed by their degree.
9. Enter the date of birth for each provider that will participate in MediPass.
10. Enter the individual Medicaid number of each provider in the practice that will participate in MediPass.
11. Enter the National Provider Identifier number for each provider in the practice that will participate in MediPass.
12. Enter the individual Social Security number for each provider in the practice that will participate in MediPass.
13. Each provider that will participate in MediPass shall sign on this line. A typed or rubber stamped name is not acceptable.
14. Enter the date signed by the provider.
15. Enter the number of hours (0-40) the provider spends in the office each week providing primary care.
16. Divide the number in column #15 by 40 hours and enter the result of the calculation.
17. Multiply the result of item #16 by the maximum patient enrollment for a full time provider, which is 1500 for physicians and 750 for ARNPs and PAs. Enter the results of the calculation performed. This is the maximum number of patients the provider can request.

18. Enter the total of column #18 here. This is the maximum number of patients the practice can request for its providers.
19. Enter the number of patients the practice wishes to accept if the same or less than indicated in column #18. This total cannot be more than total in Column #18. Should be a minimum of 50.

**MediPass Physician Extender Enrollment Form**

20. Enter the practice name.
21. Enter the practice's Medicaid provider number.
22. Enter the National Provider Identifier number.
23. Enter the location address.
24. Enter the name of each ARNP or PA who will participate as a MediPass physician extender followed by his or her title.
25. Enter the date of birth for each ARNP or PA who will participate as a MediPass physician extender.
26. Enter the individual Medicaid provider number of each ARNP or PA who will participate as a MediPass physician extender.
27. Enter the National Provider Identifier number.
28. Enter the Social Security number for each ARNP or PA who will participate as a MediPass physician extender.
29. Each ARNP or PA shall sign on this line. A typed or rubber stamped name will not be acceptable.
30. Enter date signed by the ARNP or PA.
31. Enter the number of hours (0-40) each ARNP or PA spends in the office each week providing primary care.
32. Divide the number in column #31 by 40 hours. Enter the results of the calculation performed here.
33. Multiply the number in column #32 by the maximum patient enrollment for a full time ARNP or PA which is 750. Enter the result of the calculation performed here.
34. Enter the total of column #33 here. This is the maximum number of patients the practice can request for its ARNPs and/or PA.
35. Enter the number of patients the practice wishes to accept for its ARNPs and/or PAs if same or less than indicated in column #34. The number entered here cannot exceed the total in column #34.
36. Enter the sum of Box 19 and 35. This is the Grand Total of patients the practice requests.

**YOUR APPLICATION WILL BE RETURNED TO YOU IF IT IS NOT COMPLETE  
AND CORRECT.**

**PLEASE READ AND RETAIN THIS DOCUMENT.**

**This is your Agreement and you are responsible for providing services in accordance with its contents. Do not return this agreement to the MediPass area office. These are the standards, policies and procedures for you to follow for compliance with MediPass.**

**AGREEMENT FOR PARTICIPATION IN MEDIPASS**

Whereas, the Florida Agency for Health Care Administration, is the designated state agency to establish and administer a program to provide medical assistance to low-income individuals under Title XIX of the Social Security Act as amended and is authorized to obtain services for the benefit of patients of medical assistance programs under Title XIX (Medicaid).

**MediPass General Statement of Intent**

The Agency for Health Care Administration (hereafter “Agency”) desires to enter into agreements with primary care providers and group providers participating in the Florida Medicaid program to provide primary care and management of other health care needs, through appropriate referral and authorization of Medicaid services, for certain Medicaid patients who may select or be assigned to the contracting providers or group providers. This arrangement requires the primary care provider (PCP) to: provide primary care services; make referrals for specialty care when medically necessary and appropriate; follow the results of referrals and maintain overall responsibility for the health care of beneficiaries even while under the care of a specialist; maintain a comprehensive medical record which documents the continuum of care provided; adhere to quality-of-care standards established for MediPass; and cooperate to the greatest extent possible with disease management organizations (DMO) and pre-paid mental health providers that have contracted with the Agency to provide disease management services and mental health services. This process should result in the control of utilization of medical services, which will result in decreased use of hospital inpatient resources and the provision of more cost-effective quality health care for MediPass patients. This Agreement describes the terms and conditions under which the Agreement is made and the responsibilities of the parties thereto.

**MediPass General Statement of Purpose**

The Medicaid Provider Access System (MediPass) is a primary care patient management system implemented pursuant to a waiver granted by the Secretary, Department of Health and Human Services, in accordance with Title XIX of the Social Security Act and is subject to the provisions of Florida Statutes and the Florida Administrative Code. This Agreement for Participation in MediPass incorporates by reference the terms and conditions of the Medicaid provider agreement. The Agreement for Participation in MediPass is supplementary to the usual provider participation agreement entered into by providers participating in the Medicaid program, and all provisions of the Medicaid agreement (except to the extent superseded by the specific terms of the Agreement for Participation in MediPass) shall remain in full force and effect. This agreement is to be construed in conjunction with the provider’s Medicaid provider agreement. In the event that a direct conflict exists between this agreement and the Medicaid provider agreement, then the Medicaid provider agreement shall control. The PCP and state agree to abide by all existing laws, regulations, rules, handbooks and procedures pursuant to the Medicaid Provider Access System.

## Services To Be Managed

1. **General Services.** It is agreed that the PCP will provide patient management for the following services for each patient:

- Advanced Registered Nurse Practitioner Services
- Ambulatory Surgical Center Services
- Birth Center Services
- County Health Department Services
- Chiropractic Services (first ten visits per calendar year do not need MediPass authorization.)
- Durable Medical Equipment Services
- Child Health Check-Up Services (formerly EPSDT)
- Federally Qualified Health Center Services
- Home Health Services
- Hospital Inpatient Services
- Hospital Outpatient Services
- Laboratory Services (independent laboratories do not need MediPass authorization.)
- Licensed Midwife Services
- Physician Services
- Physician Assistant Services
- Podiatric Services (first four visit per calendar year do not need MediPass authorization.)
- Prescribed Drug Services
- Rural Health Clinic Services
- Therapy Services (occupational, physical, respiratory and speech)
- X-Ray Services including portable x-rays

2. **CHILD HEALTH CHECK-UP (formerly EPSDT).** MediPass realizes that periodic well-child visits furnish PCPs with an excellent opportunity to assess children for physical, developmental, behavioral and emotional difficulties. During the first year of life, well-child visits are of particular importance. Consistent with the Medicaid Child Health Check-Up Program, formerly called the EPSDT Program, and the Medicaid Child Health Monitoring Standards, MediPass has adopted the goal that over 80% of beneficiaries will receive Child Health Check-Up screenings by age one month; during two, four, six, nine, 12, 15 and 18 months of age; and once per year for ages two through 20 years of age. The PCP will provide or manage services such that all beneficiaries under 21 years of age will receive any appropriate Child Health Check-Up screenings. It is agreed that the PCP will:

- a. Attempt to contact the parent or guardian of all new MediPass patients under 21 years of age, upon receipt of their respective addresses, at least twice within three months of their enrollment date, to perform a health risk

assessment if a screening is due. The health risk-assessment instrument must include questions regarding the Child Health Check-up history of patients under 21 years of age and questions regarding pregnancy history of female patients. The PCP may use a combination of efforts for these contact attempts, including postcards and telephone calls, and must document these efforts in the medical record or in correspondence records. The beneficiary's parent or guardian shall also be informed by the Agency through its fiscal agent, of screenings due in accordance with the periodicity schedule as specified in the Medicaid Child Health Check-Up Provider Handbook. The optional Child Health Check-Up Tracking Form may be used to document all the required components of the check-up and can be obtained from the Medicaid Child Health Check-Up Coverage and Limitations Handbook. For a copy of the Medicaid Health Check-Up Coverage and Limitations Handbook go to <http://floridamedicaid.acs-inc.com>, click on Provider Support, click on "Handbooks" and scroll down to the appropriate handbook.

- b. Use the health risk-assessments, released medical records, and other sources to identify MediPass patients who have not received Child Health Check-Ups according to the agency-approved periodicity schedule.
  - c. Attempt to contact, up to twice, any patient, who is more than two months behind in the periodicity screening schedule, to urge that the patient or guardian to make an appointment for a Child Health Check-Up.
  - d. Provide or arrange for: 1) Child Health Check-Ups according to the Child Health Check-Up Provider Handbook, to eligible patients; 2) Referrals and follow-up for needed specialty health care services as identified through the Child Health Check-Up or other assessments, and refer eligible patients to the local Medicaid office for scheduling assistance for a dental referral and/or transportation services.
  - e. Provide or manage for infants (age zero to twelve months) under the MediPass provider's care, all Agency required Healthy Start services.
  - f. Utilize correct Child Health Check-up codes as required in the Child Health Check-up Coverage and Limitations Handbook when requesting reimbursement from Medicaid for provided services.
3. **Childhood Immunizations.** MediPass promotes immunizations as an effective intervention to prevent infections in children. The PCP will provide or manage services such that children will receive vaccinations in accordance with the immunization schedule issued by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices of the U.S. Public Health Service and/or the Academy of Family Physicians. The PCP agrees to provide or manage immunization services in accordance with the current *Recommended Childhood Immunization Schedule* that was developed and endorsed by the Advisory Committee on Immunization Practices, the Committee on Infectious Diseases of

the American Academy of Pediatrics, and Infectious Diseases of the American Academy of Family Physicians. The most recent schedule may be obtained from the Centers for Disease Control website at [www.cdc.gov/nip](http://www.cdc.gov/nip); click on publications.

4. **Adult Health Screening.** MediPass recognizes that giving adults periodic health screenings improves long-term outcomes for beneficiaries. During these screenings, PCPs are afforded opportunities to conduct risk assessments, diagnose problems and furnish treatments that improve the quality of the beneficiary's life. The PCP will provide or manage services such that a health screening will be performed, if due, on patients aged 21 years or older in accordance with the recommendations in the Medicaid Physician Coverage and Limitations Handbooks. It is agreed that the PCP will:
  - a. Attempt to contact all new MediPass beneficiaries 21 years of age or older upon receipt of their respective addresses, up to twice within three months of their enrollment date, to perform an adult health screening if a screening is due. The PCP must document these efforts in the medical record or in correspondence records. Information pertaining to Adult Health Screenings can be found in the Medicaid Physician Coverage and Limitations Handbook.
  - b. Utilize correct preventative medicine codes as described in the Florida Medicaid Provider Reimbursement Handbook when requesting reimbursement from Medicaid for provided services.
  
5. **Obstetrical Services.** MediPass is committed to improved pregnancy outcomes. Pregnancy outcomes can be enhanced by early entry into prenatal care. MediPass recognizes that socioeconomic status is one of many factors that affect the incidence of low birth weight infants (where a birth weight less than 2,500 grams is considered low). While many factors that affect birth weight are beyond a provider's control, many variables may be influenced through timely and appropriate prenatal care. Consistent with Healthy People 2000: National Health Promotion and Disease Prevention Objectives and in the Health Plan Employee Data and Information Set (HEDIS), the PCP will provide or manage services such that prenatal care is initiated during the first trimester of pregnancy or, if the beneficiary is pregnant when enrolling with the PCP within four weeks of enrollment.

Upon each occurrence and pursuant to s. 383.14, F.S., the provider must offer Healthy Start Prenatal Risk Screening to each pregnant woman upon entry to care. The Healthy Start Prenatal Risk Screening instrument may be obtained through the local health department in each county. The provider must forward the completed screening instruments to the local health department and maintain documentation of the screening in the beneficiary's medical record.

If a pregnant woman refuses the Healthy Start Screening, the provider must instruct the beneficiary to indicate her decision on the screening instrument,

forward the instrument to the local health department and document the beneficiary's refusal in the medical record.

If the PCP does not directly provide the obstetrical service, s/he must ensure that the above steps are completed.

MediPass recognizes the importance of check-ups after delivery for female beneficiaries to ensure good health. MediPass is committed to providing adequate and on-going follow-up and preventive care of the postpartum female beneficiaries. As recommended in the Health Plan Employee Data and Information Set (HEDIS), the PCP will provide or manage services such that a female beneficiary will receive a postpartum visit and exam between 21 and 56 days after delivery. It is agreed that the PCP will:

- a. Provide or manage all Agency required Healthy Start services, referrals to the Special Supplemental Food Program for Women, Infants and Children (WIC), counseling and services for voluntary sterilization to all women and their partners, and the scheduled postpartum visit for the purpose of voluntary family planning to include discussion of all methods of contraception.
- b. Report all identified Hepatitis B Surface Antigen (HBsAg)-positive prenatal or recent postpartum (identified within one year of delivery) women, their infants, and contacts to the State Health Office Immunization Program (HSDI). Information collected for each individual will include: name, date of birth, race, ethnicity, address, sex (infants and contacts), laboratory test performed and date sample collected, EDC (prenatal women), and immunization dates (infants and contacts). Use of the Perinatal Hepatitis B Case and Contact Report is strongly encouraged but not required. For further information, contact the Perinatal Hepatitis B Prevention Coordinator at the local County Health Department.

**6. Specialized Services.** For a person with a developmental disability, severe mental illness or emotional disturbance or serious and chronic substance abuse it is agreed that the PCP will:

- a. Ask the beneficiary if s/he is receiving treatment or long term supports from another agency or organization and obtain authorization to seek further information from the service provider.
- b. Contact providers who are providing additional treatments and long-term supports to seek information, determine the type of treatment provided and review this information to determine the possibility of inconsistencies or the need to coordinate care. The PCP must coordinate care for persons on medications for behavioral issues or for whom a behavioral program has been prescribed for serious problems. The PCP must also coordinate care for persons with physical handicaps that have developmental disabilities or serious mental health problems.

7. **Excluded Services.** It is agreed that the PCP does not manage the physician components of ophthalmological, hearing, dental, mental health, (except for substance abuse services as defined in the Behavioral Health Provider Limitation and Coverage Handbook) or family planning services. These services, as well as other Medicaid services not specifically indicated as covered under MediPass, may be obtained by MediPass beneficiaries from a Medicaid provider of their choice. Beneficiaries in certain counties will receive Medicaid mental health services through a pre-paid mental health plan. MediPass beneficiaries must use a pre-paid mental health plan for mental health care needs in areas where a pre-paid mental health plan is an option. The PCP shall coordinate with the pre-paid mental health provider and provide patient medical information to the provider in order to ensure appropriate and timely services are provided by the pre-paid mental health provider. PCPs will not be required to authorize mental health services. However, the PCP will inform beneficiaries of pre-paid mental health services available in their area.

### **Manner of Service Provision**

1. **Medical Records.** It is agreed that the PCP will:
- a. Ensure all federal regulations regarding standards for privacy of individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 are followed.
  - b. Maintain a unified patient medical record for each MediPass beneficiary that shall include, at minimum, medical charts, prescription files, and other documentation sufficient to disclose the quality, quantity, appropriateness, medical necessity and timeliness of services performed, referred or authorized under this Agreement. Patient visit data must include history and physical, plan of treatment, diagnostic tests, therapies and prescribed regimens, follow-up notes, referrals and results from referrals, and other aspects of patient care including ancillary services. Each beneficiary's record must be legible and maintained in detail consistent with standard Medicaid, medical and professional practice, which facilitates effective internal and external peer review, medical audit, and adequate follow-up treatment.
  - c. Document in the beneficiary's record all authorizations for services that are provided by other providers along with reports from the treating providers.
  - d. Document in the medical record all Agency required Healthy Start services, referral to the Special Supplemental Food Program for Women, Infants and Children, counseling and services for voluntary sterilization to all women and their partners, and scheduled postpartum visit for the purpose of voluntary family planning to include discussion of all methods of contraception.

- e. Transfer the MediPass beneficiary's medical record to the new PCP or group provider, if requested in writing and authorized by the beneficiary, at no charge to the beneficiary, the new PCP, or the Agency.
  - f. Request medical records from known PCPs who have treated the MediPass beneficiary.
  - g. Retain a unified patient medical record for each beneficiary for five (5) years after the date of service. PCPs may convert paper records to microfilm or microfiche. However, the microfilmed or microfiched records must be legible when printed or viewed.
  - h. Allow authorized state and federal staff or their authorized representatives to audit the beneficiary's MediPass records and will make records available to the agency during normal business hours within 24-hour notice to the provider. The PCP and the agency shall make every effort to set a mutually agreeable time for the agency's visit during normal business hours and within the 24-hour period. If such a time cannot be agreed upon, the agency may set the time.
2. **Tuberculosis Reporting.** It is agreed that the PCP who makes a diagnosis of tuberculosis or provides medical services to a person with suspected or confirmed tuberculosis shall report that diagnosis by telephone or in writing, within 72 hours, to the county health department having jurisdiction for the area where the reporting provider's office or where the beneficiary's residence is located. Subsequent status reports on the beneficiary's treatment or progress shall be submitted by the PCP to the county health department at least every 3 months until the case is closed and follow-up is completed. Initial and status reporting activities must be documented in the beneficiary's medical record.
3. **Access to Care**
- a. **Twenty-Four Hour Coverage.** It is agreed that the PCP will provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week by Medicaid enrolled providers who will accept Medicaid reimbursement. This coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of 24-hour coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number. The PCP or covering medical professional must return the call within 30 minutes of the initial contact.
  - b. **Provider Coverage.** It is agreed that the PCP will arrange for coverage of primary care services during absences due to vacation, illness or other

situations which require the PCP to be unable to provide services. Coverage must be provided by a Medicaid enrolled primary care provider.

- c. **Urgent Care.** Urgent Care is defined as those 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 substantially restrict a beneficiary's activity (e.g., infectious illness, flu, respiratory ailments, etc.). Urgent care visits must be scheduled within one (1) day.
- d. **Routine Sick Patient Care.** Routine sick patient care is defined as non-urgent problems, which do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease). Routine sick patient care appointments must be scheduled within one (1) week.
- e. **Well Care.** Well care is defined as routine medical visits for one of the following: Child Health Check-up visit, family planning, routine follow-up to a previously treated condition or illness, adult physicals and any other routine visit for other than the treatment of illness. Well care appointments must be scheduled within one (1) month.

**4. Authorizations and Referrals.** It is agreed that the PCP will:

- a. Make authorizations and referrals when medically necessary and appropriate. Such referrals may be for services covered under MediPass or for services not covered under MediPass. The PCP to whom the beneficiary is referred must be a Medicaid provider unless the prescribed treatment is not covered by Medicaid. The PCP must provide the treating provider with his/her MediPass authorization number. This number is listed on the MediPass authorization card issued upon approval for MediPass participation and on the monthly MediPass Enrollment Report. All authorizations and referrals must be documented in the beneficiary's medical record along with the report from the treating provider to whom authorization was given.

Should a beneficiary require services that cannot be provided in Florida, the PCP may refer the beneficiary for out-of-state care. Prior authorization for out-of-state services requires unique authorization granted by the Medicaid Services/Medicaid Prior Authorization Unit. Do not provide your MediPass authorization number to providers for out-of-state services, as these providers will not be paid without the agency issued unique authorization number. For additional information on out-of-state services refer to the Medicaid Provider General Handbook.

- b. Provide post authorization to public providers for the provision of the following services:

1. The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and HIV.
2. The provision of immunizations.
3. School health services listed as 1 and 2 above.
4. Services rendered on an urgent basis.
5. The provision of vaccines in the event of a vaccine-preventable disease emergency.

Public providers are not required to obtain prior authorization from a MediPass PCP if providing services listed in 4.b.1-5. Public providers shall provide MediPass PCPs with the results of the office visit, including test results (Section 381.0407, F.S.).

- c. Provide post authorization to County Health Departments for the provision of emergency shelter medical screenings provided for clients of the Department of Children and Family.
  - d. Make referrals to the appropriate area Medicaid office for dental and/or transportation services.
  - e. Make referrals to appropriate specialists who participate in the Medicaid program. A list of Medicaid participating specialists can be obtained by contacting the MediPass Unit at your local Medicaid office.
  - f. Authorize appropriate follow-up consultation and/or treatment for the duration of an illness subsequent to making a referral to a specialist for consultation and/or treatment of a specific condition. This shall include services rendered by the specialist and referrals made by the specialist for related services.
  - g. MediPass enrollees may receive up to 10 visits per calendar year of reimbursable services by Medicaid participating chiropractors without prior authorization by the PCP. Any further visits shall require authorization by the PCP.
  - h. MediPass enrollees may receive up to 4 visits per calendar year of reimbursable services by Medicaid participating podiatrists without prior authorization by the PCP. Any further visits shall require authorization by the PCP.
- 5. Patient Acceptance.** It is agreed that the PCP will:
- a. Accept beneficiaries pursuant to the terms of this Agreement, including both mandatory and voluntary enrollments up to the limit set by the Agency and the PCP.

- b. Accept beneficiaries that are transferred, on an emergency basis, from one PCP to another. The accepting provider shall perform the management service without the management fee for the balance of the acceptance month to preclude payment of two management fees for the same beneficiary in the same month.
  - c. The PCP will not discriminate against individuals eligible to enroll on the basis of health status or need for care services.
  - d. The PCP will observe the patient rights standards as outlined in 42CFR 438.100(c) and 381.026 F.S.
  - e. Upon enrollment in the program, the beneficiary will be provided program information via the MediPass Client Brochure. The PCP may also obtain a copy of the MediPass Client Brochure by contacting the local MediPass office.
6. **ARNPs and PAs.** It is agreed that the PCP will supervise, in accordance with licensing board regulations, ARNPs and PAs who are used to expand the PCP's MediPass patient limit as listed in the Manner of Service Provision section, 15 a, d and e.
7. **MediPass Training.** It is agreed that the new PCP will arrange for attendance by appropriate staff at a MediPass training program provided by the area Medicaid office staff. This training covers policy and billing procedures necessary to operate within MediPass. Attendance at this training is required within the first 30 days of enrollment and is mandatory before patient enrollments will be processed. It is agreed that existing PCP will attend or arrange in-service trainings to obtain updated MediPass policies.
8. **Disease Management Initiatives.** It is agreed that the PCP will cooperate to the greatest extent possible with disease management companies that have contracted with the Agency to provide disease management services to MediPass beneficiaries by:
- a. Allowing Disease Management Organization (DMO) representatives to review medical records of beneficiaries who have been identified by the agency as eligible for DMO services.
  - b. Coordinating and communicating with DMO representatives to establish a plan of care for DMO beneficiaries.
  - c. Incorporating DMO recommendations into the MediPass patient plan of care.

- 9. Pre-Paid Mental Health Initiative.** It is agreed that the PCP will cooperate to the greatest extent possible with pre-paid mental health plans that have contracted with the Agency to provide mental health services to MediPass beneficiaries by:
- a. Requesting specialty consultations from the pre-paid mental health plan for evaluation of the beneficiary as appropriate.
  - b. Obtain written documentation of the consultation report from the mental health care provider.
  - c. Coordinate with the pre-paid mental health plan provider to determine the physical and mental health care services needed by the beneficiary and to discuss any concerns related to drug interactions.
  - d. Participate in educational outreach activities provided by the mental health care provider to assist in identification, management, and referral of clinical issues related to mental health diagnoses.
  - e. Participate in satisfaction surveys conducted by the mental health care plan and identify any deficiencies found in responses to request for consultations or referrals.
- 10. MediPass Change of Status.** It is agreed that the PCP will notify the appropriate MediPass unit at the local Medicaid office, within five working days in writing, of a change in provider phone number, mailing/location address, addition or deletion of providers or provider extenders, age limit changes or changes in provider hours listed on the Agreement. It is agreed that the PCP will notify the MediPass unit at the local Medicaid office immediately of any action taken against the medical license or loss of license. The PCP agrees to notify the MediPass unit at the local Medicaid office of any report filed with the National Practitioner's Data Bank within 30 days of the action.
- 11. Change of Ownership.** It is agreed that the PCP will notify the agency of a change of ownership 60 working days prior to the change of ownership.
- 12. Hospital Privileges.** It is agreed that the PCP will maintain hospital privileges or enter into an agreement with another Medicaid or MediPass provider for admitting coverage as required for the performance of the PCP's practice. The Agency reserves the right to waive the hospital privileges requirement in areas where access is a concern and a written agreement between the PCP and hospital to admit the beneficiary, follow the beneficiary and release medical records regarding the beneficiary's hospital stay exists. It is agreed that the PCP will notify the MediPass program of changes or terminations in hospital privileges.

Upon approval, the Medicaid program will initiate a hospitalist program with certain hospitals within certain counties of the state. All MediPass

beneficiaries admitted to these facilities will be admitted and followed by a hospitalist. The PCP agrees to coordinate care with the hospitalist at the time of admission and discharge. To obtain more information about the hospitalist program, contact the MediPass unit at the local Medicaid office.

- 13. Primary Care Services Billing Number.** It is agreed that the PCP will provide and bill for primary care services using their assigned MediPass provider number. This number must be a working number used for the billing of office visits and related procedures. It may not be used solely as a referral number.
- 14. Hospital Affiliated MediPass Providers.** It is agreed that a hospital affiliated PCP may not bill outpatient charges for office visits and related procedures. Primary care services provided in hospital-owned outpatient clinics and satellite facilities cannot be billed on the UB-92 claim form. Physician services must be billed to Medicaid using the HCFA 1500 claim form.
- 15. Limits on Number of Patients.**
  - a. M.D.s and D.O.s may have no more than 1,500 patients per each participating full time equivalent primary care provider plus 750 patients per each full time equivalent primary care Advanced Registered Nurse Practitioner or Physician Assistant under their supervision; or, the number specified by the PCP, whichever is less.
  - b. M.D.s and D.O.s practicing at more than one MediPass location may have no more than the sum of 1,500 patients per each full-time equivalent PCP.
  - c. M.D.s and D.O.s may have no more than 3,000 active patients: MediPass, Medicaid Fee-for-Service, Medicaid Prepaid Health Plan, Health Maintenance Organization (HMO), Medicare or commercial entity. An active patient is one that is seen by the professional at least three times within a calendar year.
  - d. Advanced Registered Nurse Practitioners or Physician Assistants (ARNPs or PAs) participating in MediPass, as PCPs or physician extenders, may have no more than the total of 750 patients regardless of the number of locations at which they practice. Advanced Registered Nurse Practitioners and Physician Assistants enrolling as PCPs will only be eligible for voluntary patient enrollments in all counties except Bay, Marion, and Escambia Counties where ARNPs and PAs are eligible for both mandatory and voluntary patient assignment.
  - e. PCPs may increase their number of patients at any time, upon approval of Medicaid, (not to exceed the maximum number of patients per FTE provider and their supervised ARNPs and PAs) by sending a written request to the MediPass unit in the local Medicaid office.

- f. PCPs must agree to a minimum enrollment of 50 MediPass patients per location unless otherwise waived by the Agency, in writing.

**16. Patient Choice of MediPass Provider.**

- a. The Agency will permit patients to choose from among participating primary care providers or group providers. PCPs shall be required to accept patients who have chosen them up to the limit approved in the Manner of Service Provision section of this Agreement, 15 a, b, c, d, e and f.
- b. Each beneficiary who does not choose a PCP will be assigned to a participating PCP in the beneficiary's county of residence.
- c. Beneficiaries will be permitted to change PCPs upon request by calling the MediPass Unit at the local Medicaid office.

**17. Patient Disenrollment By Provider.**

PCPs may request the disenrollment of a patient by notifying the Medicaid patient by certified mail and sending a copy of the letter to the MediPass unit at the local Medicaid office. Beneficiaries may be disenrolled only if the provider/patient relationship is not satisfactory or if the PCP feels a specialist can better serve the beneficiary's medical needs. The PCP must continue to provide MediPass managed services to patients until the patient disenrollment process is complete and the beneficiary is enrolled with another PCP, which may take two to six weeks.

The PCP may not request disenrollment of a beneficiary because of an adverse change in the beneficiary's health status, or because of the beneficiary's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the PCP seriously impairs the PCP's ability to furnish services to either this particular beneficiary or other beneficiaries). In the event a beneficiary's ongoing enrollment impairs services provision as previously described, the PCP may request the Agency's authorization to disenroll the beneficiary on a case-by-case basis.

**18. Patient Enrollment/Disenrollment Effective Date.**

- a. Patient enrollments are effective at 12:01 am on the first day of the month.
- b. Patient disenrollments are effective at midnight on the last day of the month.

**19. Participation of Employees of Group Providers.**

- a. Employees of a group with more than one MediPass location must practice at the site under which they have enrolled for the number of hours indicated on the Agreement for Participation in MediPass.
- b. Group providers are required to have each employee who participates in MediPass as a PCP, Advanced Registered Nurse Practitioner or Physician Assistant to have an active Medicaid provider number.
- c. Group providers must have patients assigned to the group provider and not directly to the primary care providers who are employed by the group provider. However, a group provider may internally assign patients in any fashion they wish as long as it does not exceed 1,500 patients per each full time equivalent primary care provider (M.D., D.O.) and 750 patients per each full time primary care Advanced Registered Nurse Practitioner or Physician Assistant.

**20. Provision of Patient Data, Utilization and Cost Reports.** It is agreed that the PCP will review patient utilization and cost reports provided by the Medicaid program and advise the Medicaid program within 10 days of receipt of any noted errors, omissions or discrepancies. It is agreed that the Agency will:

- a. Provide the PCP with a listing of patients each month via the MediPass Enrollment Report. All patient information contained on this report is strictly confidential and under no circumstances shall this information be duplicated and/or provided to anyone for any purpose other than fulfilling the terms of this agreement. Receipt and use of this information will be governed by all applicable sections of 42 CFR 431.300, and provisions of the Health Insurance Portability and Accountability Act. The MediPass Enrollment Report is available through the Internet. To receive a MediPass Enrollment Report via the internet, contact the MediPass Unit at the local Medicaid office and complete a MediPass Internet Access Form.
- b. Provide the PCP with appropriate reports of service utilization and costs for MediPass services. This report is provided monthly and attached to the remittance voucher sent to the MediPass provider.

**21. Provider Service Networks.** PCPs who elect to participate as primary care providers in a Medicaid Provider Service Network (PSN) may no longer participate as MediPass providers at the location that is enrolled in the PSN. However, PSN primary care providers who are also enrolled as a Children's Medical Services (CMS) Network provider may continue to serve as the MediPass PCP for those CMS Network patients at the location that is enrolled in the PSN. In the event that the MediPass provider terminates his/her participation in the PSN, the patients to whom the physician was serving under the PSN will remain in the PSN and will be assigned to another provider within the PSN. To

obtain more information about Provider Service Networks, contact the MediPass unit at the local Medicaid office.

**22. Minority Physician Network Programs and Pediatric Emergency Room Diversion Programs.** PCPs who elect to participate in the Minority Physician Network Program or Pediatric Emergency Room Diversion Program may no longer participate as a MediPass PCP at the location that has enrolled in the program. However, providers enrolled in these programs, as well, as the Children's Medical Services (CMS) Network and who have disease management enrollees will continue to treat both the CMS or DMO enrollees as a participating MediPass PCP. In the event that the PCP terminates his/her participation in the program, the patients to whom the physician was serving under the special program will remain in the program and will be assigned to another PCP within the program unless the patient calls the MediPass unit at the local Medicaid office to enroll with the terminating PCP. To obtain more information about the Minority Physician Network program and Pediatric Emergency Room Diversion program, contact the MediPass unit at the local Medicaid office.

**22. Exclusive Provider Organization (EPO).** PCPs may elect to participate in the Exclusive Provider Organization (EPO). The patients (excluding the Children's Medical Services and disease management enrollees) enrolled with the MediPass provider will become members of the EPO. The provider will remain in MediPass for the purpose of treating both the CMS or DMO enrollees assigned to his/her practice. In the event that the PCP terminates his/her participation in the EPO, the patients to whom the physician was serving under the EPO will remain in the EPO and will be assigned to another provider within the EPO unless the patient calls the MediPass unit at the local Medicaid office to enroll with the terminating PCP. To obtain more information about the EPO, contact the MediPass unit at the local Medicaid office.

## **Enrollment**

- 1. Marketing.** Any techniques used to recruit MediPass patients is strictly prohibited. Offers of material or financial gain may not be made to anyone as an incentive to enroll.
- 2. Outreach.** It is agreed that if the PCP wishes to use materials and announcements that reference MediPass, s/he must submit such materials to the MediPass Unit at the local Medicaid office for review and approval prior to use. Outreach strategies may include, but are not limited to, brochures, fact sheets, posters, handouts, and presentations. The outreach materials must be informational in nature and not intended to influence enrollment. The use of any unauthorized outreach materials is strictly prohibited.

## **Method of Payment**

- 1. Management Fee.** It is agreed that the Agency or Medicaid program will pay each primary care provider or group provider a management fee of \$2 monthly for each MediPass patient the provider has as of the first day of each month. (The monthly management fee is subject to change based upon the appropriation of legislative funding and will be adjusted accordingly.) If a patient is transferred on an emergency basis, the accepting MediPass provider will provide the patient management service without charge for the balance of the acceptance month.
- 2. Service Reimbursement.** It is agreed that the Agency or Medicaid program will provide Medicaid reimbursement for medical services rendered by the MediPass provider in accordance with the standard Medicaid fee for service schedules and policy. For those MediPass providers eligible for cost-based reimbursement (e.g. county health departments, federally qualified health centers, and rural health clinics), the Agency will provide Medicaid reimbursement in accordance with the provider's established encounter rate.

## **Special Provisions**

- 1. Termination (General).**
  - a. This Agreement terminates upon the death of the primary care provider, the provider going out of business or being terminated or debarred from participation of any federal health care program including but not limited to, Medicaid or Medicare programs.
  - b. Either party may terminate this agreement without cause upon 30 days written notice.
  - c. The Agency may terminate this Agreement upon 30 days written notice when a provider is found to be out of compliance with any of the provisions of the Agreement.
  - d. Providers terminated from MediPass may reapply after a one (1) year period. The Agency may waive, in writing, the 1-year waiting period in areas where access is a concern.
  - e. It is agreed that the provider must make a good faith effort to give written notice of termination within 15 days of issuance of the termination notice by the Agency, to each enrollee who is assigned to his/her practice.
- 2. Termination (Sole, Group or Public Funded Provider).**

Primary care providers must notify the MediPass Unit in the local Medicaid office, in writing, at least 30 days in advance of termination of their MediPass

status to allow for patient reassignment. The primary care provider must continue to provide MediPass managed services to patients until the patient disenrollment process is complete and beneficiaries are enrolled with another MediPass primary care provider. This process may take two to six weeks.

**3. Termination of Participating Providers in a Group.**

Group providers must notify the MediPass unit in the local Medicaid office within 30 days whenever a participating provider (M.D., D.O.), Advanced Registered Nurse Practitioner or Physician Assistant employee leaves the employment of the group provider or no longer functions as a primary care provider. If after 90 days, new staff has not been hired to support the group provider's MediPass enrollment within the guidelines specified in the Manner of Service Provision section, 14a, b, c, d and f, Medicaid will reassign the patients.

- 4. Provider Enrollment.** A provider is not entitled to enrollment in the MediPass provider network. The Agency may limit its provider network based upon the following considerations: beneficiary access to care, provider availability, provider quality standards and quality assurance processes, cultural competency, demographic characteristics of beneficiaries, practical standards, service wait times, provider turnover, provider licensure and accreditation history, program integrity history, peer review, Medicaid policy and billing compliance records, clinical and medical record audit findings, and such other areas that are considered necessary by the agency to ensure the integrity of the program.

The Agency may continue a provider's participation in the MediPass program by entering into a new Agreement every 2 years. A provider's continued participation is based in part upon, but not limited to, meeting recredentialing standards, compliance with all terms and conditions of the Agreement for Participation in MediPass, the Medicaid Agreement, the Medicaid provider handbooks, Florida Statutes, and/or the Laws of Florida.

The Agency reserves the right to not accept a new Agreement for Participation in MediPass from providers who were previously terminated from the program or who were non-compliant with the terms and conditions of this Agreement at the time of disenrollment.

- 5. Credentialing Standards.** It is agreed that the Agency and/or Medicaid program may enroll primary care providers or group providers who have met the following credentialing standards set forth in this Agreement for Participation in MediPass:
- a. Have sent a completed Medicaid Agreement with a copy of each provider's current medical license to Medicaid's fiscal agent and are approved Medicaid providers.

- b. Have sent a completed Attachment I – Agreement for Participation in MediPass and Attachment II – MediPass Provider Enrollment Form to the Agency.
- c. Have attested to the correctness/completeness of the MediPass provider’s application.
- d. Have attested that the total active patient load (all populations with Medicaid Fee-For-Service, Medicaid Health Maintenance Organization (HMO), Medicare or commercial coverage) is no more than 3,000 patients per primary care provider. An active patient is one that is seen by the professional a minimum of three times per year
- e. Have made a statement regarding any history of loss or limitation of privileges or disciplinary activity.
- f. Have an active Florida medical, nursing, or physician assistant license (or, for providers within 50 miles of Florida, an active license to practice in their home state.)
- g. Have not received any revocation, suspension, or sanctions of the provider’s state license by the Division of Medical Quality Assurance, Agency for Health Care Administration, or Department of Health Practitioner Board.
- h. Have no limitations or conditions on the provider’s medical license due to acts of sexual misconduct.
- i. Have no open investigations for fraud or abuse, with exception of routine utilization reviews including SURS, at the time of initial application.
- j. Have no ongoing investigation(s) by Medicaid Program Integrity, Medicare or Medicaid Fraud Control Unit.
- k. Have no sanctions imposed on the provider by Medicaid or Medicare.
- l. Have no over payments due to Medicaid or Medicare.
- m. Have not paid three or more malpractice claims judgments within the past five years based on the date of act/omission.
- n. Have good standing of privileges at the hospital designated as the primary admitting facility by the provider or have entered into an agreement with another Medicaid or MediPass provider for admitting coverage.
- o. Have submitted copies of valid Drug Enforcement Administration (DEA) certificates, where applicable.

- p. Have received a good standing report on a credentialing site visit survey (see Exhibit A).
- 6. Recredentialing Standards.** The process for periodic recredentialing shall include the following:
- a. Recredentialing shall be implemented at least every two years. Providers are required to return recredentialing information within set deadlines as stated in the recredentialing notification letter.
  - b. MediPass, or its agent, shall conduct periodic reviews of information from the National Practitioner Data Bank, State Medical Board, CMS (Center for Medicaid/Medicare Services (formally HCFA), and other performance data. There shall be verification of current standing for each primary care provider on, including but not limited to, item #5 a-p, Credentialing Standards, of this Agreement for Participation in MediPass.
- 7. Quality of Care Standards.** Providers will adhere to or exceed the quality assurance standards established by MediPass.
- a. Comprehensive Diabetes Care.
    - 1. Diabetic Retinal Examinations. MediPass is committed to reducing the incidence of diabetes-induced blindness in MediPass beneficiaries. Early intervention and continual monitoring of diabetic eye disease could reduce the incidence of diabetes-related blindness. Based on guidelines proposed by the American College of Physicians, the American Diabetic Association, and the American Academy of Ophthalmology, the MediPass provider will provide or manage services such that beneficiaries with a history of diabetes will receive at least one fundoscopic exam every 12 months.
    - 2. Glycohemoglobin Levels (HgA1C). The parties acknowledge that tight control of blood glucose levels can delay the onset and slow the progression of many of the side effects from diabetes. Glycohemoglobin is one laboratory indicator of how well a beneficiary's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, the MediPass provider will provide or manage services such that beneficiaries with a history of diabetes will receive glycohemoglobin determinations at least twice a year.
    - 3. Lipid Levels. The parties recognize the direct link between hyperlipidemia, secondary hyperlipoproteinemias and diabetes

mellitus. By closely monitoring lipids and lipoprotein levels in diabetics, better control and maintenance of diabetes is possible. Consistent with the recommendations of the American Diabetes Association, the MediPass provider will provide or manage services such that beneficiaries with a history of diabetes will receive lipid and lipoprotein determinations annually. If any anomalies are found in the annual baseline, additional studies should be conducted as medically necessary.

- b. **Mammography Screening.** The parties recognize that breast cancer is one of the most common malignancies affecting women. Early detection and treatment of breast cancer improves the probability of long-term survival. Mammography screening is one technique used for detection of breast cancer. The MediPass provider will provide or manage services such that female beneficiaries will receive mammography screening consistent with the recommendations in the Medicaid Physician Coverage and Limitations Handbook.
- c. **Cervical Cancer Screening.** The parties are committed to reducing the incidence of cervical cancer. Early detection and treatment of cervical cancer improves the probability of long-term survival. Cervical cancer can be detected in its early stages by regular screening using a Papanicolaou (Pap) test. Consistent with the recommendations by the American College of Obstetricians and Gynecologists, American Medical Association, American Cancer Society and the U.S. Preventive Service Task Force, the MediPass provider will provide or manage services such that female beneficiaries between ages 18 and 64 years, or if younger than 18 years, who have been sexually active, will receive at least one Pap test every two years.
- d. **Access to Care.** MediPass is a primary care case management program that is designed to improve access to care for beneficiaries. Access to care incorporates a diverse and broad spectrum in health management. Two (2) goals involving access to care are discussed below:
  1. Twenty-Four Hour Coverage. The parties realize that an important aspect of a “gate-keeping” function is based on the availability of the provider(s). A MediPass provider must be continually accessible to render clinical decisions. The patient must be able to contact the provider through the use of the provider’s daytime phone number. All providers will arrange for primary care coverage for services, consultation, or approval for medically necessary referrals 24 hours per day, seven days per week. The MediPass provider will provide or manage services such that the chosen method of 24-hour coverage will connect a beneficiary’s call to someone who can render a clinical decision. The MediPass provider or his/her designee must contact the patient within 30 minutes of the initial contact.

2. Utilization. In the MediPass model, primary care providers are expected to monitor the costs and medical appropriateness of care provided to beneficiaries. MediPass is committed to increasing the quality of care that beneficiaries receive while reducing the use of unnecessary services. MediPass has adopted the goal that all beneficiaries will receive appropriate authorized care for the medically necessary covered services. The MediPass provider will review and assess patient utilization and cost reports provided by the Medicaid program to ensure appropriate use of medical services are provided to MediPass patients.

- e. **Low Birth Weight.** MediPass recognizes that socioeconomic status is one of many factors that affect the incidence of low birth weight infants (where a birth weight less than 2,500 grams is considered low). While many factors that affect birth weight are beyond a provider's control, many variables may be influenced through timely and appropriate prenatal care. Consistent with recommendations in Medicaid HEDIS, the MediPass Primary Care Provider will provide or manage services such that timely and early prenatal care will be initiated during the first trimester of pregnancy or, if the beneficiary is pregnant when enrolling with the provider, within four weeks of enrollment.
- f. **Domestic Violence.** MediPass providers shall routinely screen their patients for signs of domestic violence, and shall provide referral services to applicable community domestic violence prevention agencies.

## **8. Sanctions.**

- a. It is agreed that the Agency and/or Medicaid program may impose sanctions against individual or group providers, including but not limited to:
  - 1. Providers found to be out of compliance with any provision of this Agreement for Participation in MediPass, the Medicaid Agreement, the Medicaid provider handbooks, Florida Statutes and/or the Laws of Florida may have their enrollments limited to current enrollees or be terminated from the program.
  - 2. Providers found to be out of compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, such as provisions apply to the Medicaid program will be terminated from the program.

3. Providers found to be out of compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 will be terminated from the program.
4. Providers who fail to keep their enrollment lists confidential will be terminated from the program.
5. Providers who attempt to have beneficiaries enrolled without their permission will be terminated from the program.
6. Providers who attempt to persuade or coerce beneficiaries into changing Medicaid managed care programs will be terminated from the program.
7. Providers being investigated for fraud or abuse by Medicaid or Medicare will have their enrollments limited to current enrollees or will be terminated from the MediPass program until the investigation is completed.
8. Providers who fail to demonstrate appropriate controls for utilization of medical services will have their enrollments limited to current enrollees or will be terminated from the program.
9. Providers who are prescribing medication inappropriately or inefficiently as determined by the agency will have their enrollments limited to current enrollees or be terminated from the program.
10. Providers engaging in a pattern of prescribing medical drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients will be terminated from the program.
11. Providers who fail to comply with the MediPass credentialing or re-credentialing requirements, which includes providing recredentialing information within given deadlines, will be denied participation or be terminated from the program.
12. Providers who report incomplete, misleading or false information on the Medicaid provider enrollment application, the MediPass application, a request for prior authorization for Medicaid services, a drug exception request, a Medicaid cost report, or any other information provided to CMS or the State will be denied participation in the MediPass program or be terminated from the program.
13. Providers who fail to comply with the Americans with Disabilities Act will have their enrollments limited to current enrollees until deficiencies are corrected or may be terminated as MediPass providers. Failure to correct deficiencies within an agreed upon time will result in termination from the program.

14. Providers who authorize the provision of services or make referrals which are determined by the Agency to be inappropriate, medically unnecessary, excessive, or harmful to the beneficiary may be terminated from the MediPass program.
15. Providers who fail substantially to provide medically necessary services required, under law or under this Agreement, to a beneficiary covered under the Medicaid program will be denied participation or be terminated from the program.
16. Providers who ordered, prescribed, or provided services and are found liable for negligent practice resulting in death or injury to the provider's patient will be denied participation or be terminated from the program.
17. Providers who impose on beneficiaries premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program by reason of the provider's billing the Medicaid program for the same services will be terminated from the program.
18. Providers who act to discriminate among beneficiaries on the basis of their health status or need for health care services will be terminated from the program.
19. Providers who misrepresent or falsify information that it furnishes to a beneficiary or health care provider will be denied participation or be terminated from the program.
20. Providers for whom the agency receives reliable information of patient abuse or neglect or of any act prohibited by s. 409.920 will be terminated from the program.
21. Providers whose license have not been renewed, or have been revoked, suspended, or terminated, for cause, by the licensing agency of any state will be terminated from the program.
22. Providers who fail to make available or refuse assess to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the Agency, the Attorney General, a state attorney, or the Federal Government will be terminated from the program.
23. Providers who fail to make available such Medicaid-related records as the Agency finds necessary to determine whether Medicaid payments are or were due and the amounts thereof will be terminated from the program.

24. Providers who fail to maintain medical records at the time of service, or prior to service, if prior authorization is required, demonstrating the necessity and appropriateness of the goods and services rendered will be terminated from the program.
  25. Providers who fail to retain a unified medical record for each beneficiary for five (5) years after the date of service will be terminated from the program.
  26. The Agency may impose additional sanctions when such action is considered to be in the Agency's best interest.
- b. Duration of the Sanction.  
Unless the duration of a sanction is specified, a sanction shall remain in effect until the Agency/Medicaid program determines that the sanction be lifted.

## DEFINITIONS

**Agency** - The Florida Agency for Health Care Administration (AHCA).

**ARNP** - Advanced Registered Nurse Practitioner. Certified under Section 464.012, F.S.

**Authorize** - The treating provider may not bill Medicaid for services provided to a MediPass patient without appropriately obtaining the authorization number from the primary care provider.

**Child Health Check-up** (formerly EPSDT - Early and Periodic Screening, Diagnosis and Treatment) – A Child Health Check-up is a comprehensive preventive health care program for Medicaid-eligible children under age 21 that is designed to identify and correct medical conditions before the conditions become serious and disabling. The Child Health Check-up Optional Screening Form can be obtained from the Medicaid Child Health Check-up Coverage and Limitations Handbook.

**Disease Management**- An integrated, systematic health care management approach to improve patient outcomes and lower medical cost for patients living with specific chronic health conditions.

**Disease Management Organization (DMO)**- An entity that contracts with the Agency to provide disease management services to MediPass beneficiaries living with chronic illnesses.

**Emergency Services and Care**- The medical screening, examination, and evaluation by a physician, or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care treatment or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

**Exclusive Provider Organization (EPO)**- An organization licensed in accordance with 627 F.S., which provides medical services to enrollees under the contract with the State Agency.

**Fiscal Agent** - A private corporation under contract with the Agency for Health Care Administration to receive and process Medicaid claims.

**Full Time Equivalent (FTE)** - A MediPass provider or a provider extender, that practices 40 or more hours per week.

**Group Provider** - A Medicaid participating medical group provider that is comprised of two or more health care practitioners who practice their profession at a common location whether or not they share common facilities, supporting staff, or equipment, and which organization possesses a federal employer identification (FEID) number.

**Hospital Affiliated Primary Care Provider** - A primary care program that is owned or operated by a hospital.

**Management** - Coordination of the delivery of MediPass covered medical services. If not provided directly, necessary medical services must be arranged through referral and authorized by the primary care provider.

**Management Fee** - The monthly fee paid to the MediPass provider for each enrollee s/he manages. The management fee is \$2 per patient per month. The monthly management fee is based upon the appropriation of legislative funding and will be adjusted accordingly.

**Medicaid** - The Florida Medicaid program.

**Medical Necessity or Medically Necessary** – Any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, cure, alleviate or preclude deterioration of a condition that threatens life, causes pain or suffering or results in illness or infirmity, which goods and services are provided in accordance with generally accepted standards of medical practice.

**MediPass Pilot Project/ Pediatric Emergency Room Diversion Project**- A project(s) being used to test new approaches to managing the access to and utilization of appropriate health care and serves to improve the quality of care and cost effectiveness of the MediPass program.

**MediPass Services** - Those Medicaid services described in this Agreement that must be provided or managed for each patient by the beneficiary's primary care provider at a fixed medical site.

**Minority Physician Network Program/ Pediatric Emergency Room Diversion Program**- A program(s) being used to test new approaches to managing the access to and utilization of appropriate health care and serves to improve the quality of care and cost effectiveness of the MediPass program.

**Other Medicaid Services** - All Medicaid services other than MediPass managed services.

**PA**- Physicians Assistant Certified under Section 458.347, F.S.

**Patient/Enrollee/Beneficiary** - A Medicaid beneficiary who is enrolled in MediPass.

**Pre-paid Mental Health Plan**- A comprehensive mental health provider under contract with the Agency on a prepaid, capitated basis to provide certain mental health services to a particular population.

**Primary Care** - The ongoing responsibility for medical care, provided at the beneficiary's first point of contact with the health care system. Primary care includes treatment of illness and injury, health promotion, identification of individuals at special risk, early detection of serious disease and referral to specialists when appropriate.

**Primary Care Provider** - A Medicaid participating primary care provider (M.D., D.O., ARNP or PA ) or group provider practicing one of the following primary care specialties: general practice, family practice, pediatrics, internal medicine, obstetrics or gynecology (or in another provider specialty that has been approved by the Agency) who has signed this Agreement.

**Provider Service Network**- (PSN)- A network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions.

**Public Provider-** A County Health Department or a federally qualified health center funded under the Public Health Services Act through the Florida Department of Health.

**Routine Sick Patient Care-** Non-urgent care for problems which do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

**Specialist** - A provider whose practice is limited to a particular branch of medicine or surgery, including one who, by virtue of advanced training, is certified by a specialty board as being qualified to hold himself/herself out as a person possessing special knowledge in that area of medicine.

**Unified Medical Record-** All medical, fiscal, professional, and business records on all services provided to a patient; including at a minimum, medical charts, prescription files, and other documentation sufficient to disclose the quality, quantity, appropriateness, medical necessity and timeliness of services performed, referred or authorized, patient visit data which must include history and physical, plan of treatment, diagnostic test, therapies, and prescribed regimens, follow-up notes, referrals, results from referrals, and ancillary services.

**Urgent Care-** Care for those 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 a member's activity (e.g., infectious illness, flu, respiratory ailments, etc.)

**Well Care-** A routine medical visit for one of the following: Child Health Check-up visit, family planning, routine follow-up to a previously treated condition or illness, adult physicals and any routine visit other than for the treatment of illness.

**EXHIBIT A  
MEDIPASS CREDENTIALING SITE VISIT SURVEY REPORT**

MEDIPASS PROVIDER \_\_\_\_\_ MEDIPASS PROVIDER # \_\_\_\_\_  
 DBA \_\_\_\_\_ TAX ID # \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ OBTAIN FROM PROVIDER WHEN MAKING APPT OR AT SV  
 HOURS OF OPERATION \_\_\_\_\_  
 MULTIPLE SITES YES \_\_\_\_\_ NO \_\_\_\_\_  
 CONTACT PERSON \_\_\_\_\_ TITLE OF CONTACT \_\_\_\_\_  
 PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 IF AVAILABLE  
 DATE AREA OFFICE RECEIVED COMPLETED APPLICATION \_\_\_\_\_ DATE SURVEY COMPLETED \_\_\_\_\_  
 INITIAL CREDENTIALING \_\_\_\_\_ RECREDENTIALING \_\_\_\_\_ FOLLOW-UP VISIT \_\_\_\_\_

STANDARDS	POINTS PER FILE	YES	NO	CRITERIA	COMMENTS
<b>ACCESSIBILITY</b>					
Adequate Parking	2	Y	N	Without technical details or formulas, the surveyor is to determine if there are reasonably accessible parking spaces for the practice.	
Disabled Access					
Parking	2	Y	N	Check parking area and external area of building for general access by the disabled. There needs to be at least one designated handicapped space.	
Office	2	Y	N	This includes items such as: handicapped ramps available externally, doorways, handrails, at least one accessible restroom, etc. Wheelchair accessible restroom can be anywhere in the same building as the physician's office; it does not have to be in the same suite. If no, what is their alternate plan?	
Interpreter Services Available When Requested	2	Y	N	There is a protocol in place for accommodating the hearing impaired.	
Telephone Access	2	Y	N	Patients have access to a nearby public phone for purposes related to the office visit, e.g., arranging transportation.	
Patient Health Education Materials	2	Y	N	Determine whether patients have access to patient health education materials, e.g., brochures, pamphlets, etc. A thorough review of the materials' content is not necessary.	

**SUBTOTAL POINTS - PAGE 1** \_\_\_\_\_

EXHIBIT A

PROVIDER

STANDARDS	POINTS	YES	NO	CRITERIA	COMMENTS
<b>ADEQUACY &amp; CLEANLINESS</b>					
OF SPACE					
	1	Y	N	The area appears reasonable for patients' use during their wait.	
Waiting Room Size	1	Y	N	The area appears clean and free of clutter.	
Cleanliness					
Exam Rooms Size	2	Y	N	There is a reasonable amount of space to conduct an exam.	
Privacy	2	Y	N	Efforts made to keep doors closed during exams and consultation.	
Cleanliness	2	Y	N	Area appears clean and free of clutter. Clean drape sheets or gowns are available.	
Infection Control	3	Y	N	Inspect exam rooms for appropriate infection control, e.g., alcohol, betadine, sharps containers, red bags and location of waste container and hand washing facilities. Check sterilization procedures.	
Bathrooms Size	1	Y	N	The area appears reasonable for patients' use.	
Cleanliness	1	Y	N	The area looks clean and is free of litter and trash.	
Infection Control	2	Y	N	Inspect bathrooms for appropriate infection control, e.g., handwashing facilities and supplies.	
<b>PERSONNEL</b>					
License	3	Y	N	The MediPass provider(s) license is available upon request for ARNPs, PAs and physicians listed on the application.	
General Manner/ Courtesy	2	Y	N	Observe the general manner and courtesy of the office staff and provider(s) throughout the visit.	

SUBTOTAL POINTS – PAGE 2 \_\_\_\_\_

STANDARDS	POINTS	YES	NO	CRITERIA	COMMENTS
<b>OFFICE PROTOCOLS</b>					
Protocols to Inform Patients of Diagnostic Procedures, Including Surgery if applicable, the Expected Results and the Associated Risks	2	Y	N	It is sufficient for the physician/provider to document that the patient has received information about and agrees to the procedure performed. Inquire about the use of consent forms if surgery is performed.	
Protocols for Patient Refusal of Treatment	2	Y	N	Inquire about protocols for patient refusal of treatment. The physician/provider should, in all cases, document in the medical record when a patient refuses treatment. Depending on the circumstances, i.e., seriousness, a patient may also be asked to sign a “refusal of treatment” form.	
Protocols Addressing Confidentiality – including Storage of Medical Records	2	Y	N	Inquire about protocols in place to address confidentiality. The provider should be aware that the release of any information to a third party should be preceded by the patient signing a “release of medical information” form. Verify that precautions are taken to prevent unauthorized access to the patient records.	
Protocols for Secured Storage	2	Y	N	Inquire about protocols to ensure accountability and management of controlled substances, prescription pads and sample drugs.	

**SUBTOTAL POINTS – PAGE 3** \_\_\_\_\_

#### INSTRUCTIONS FOR PAGES 4 AND 5

The surveyor will complete either page 4 or page 5 – Not both.

#### Initial credentialing – Complete page 4

- Request a sample of 5 medical records for current Medicaid patients and review them for the items on page 4. After completing page 4, go to page 6. Do not complete page 5.
- If this is a new Medicaid provider and no Medicaid files are available yet, do not complete 4 or 5. If the area wishes to recommend credentialing of this provider, the recommendation must be provisional with a revisit scheduled within 6 months to review medical records.

#### Recredentialing – Do not complete page 4 – Go to page 5.

- Request a sample of 5 MediPass records and complete page 5
- If major problems are noted in the records, complete the credentialing review with a provisional recommendation and request that a full medical record review be scheduled.

**Special Note** – Legibility – A second surveyor must examine any record judged to be illegible. No points are to be given for an illegible record. Attach a copy of a sample from one record to the site visit for the Credentialing Committee.

EXHIBIT A  
INITIAL CREDENTIALING REVIEW

PROVIDER \_\_\_\_\_

STANDARDS	POINTS	FINDINGS – ENTER Y, N OR N/A					TOTAL POINTS**	COMMENTS
		1	2	3	4	5		
<b>MEDICAL RECORDS CONTAIN DOCUMENTATION OF ATTEMPTS TO COMPLY WITH THE FOLLOWING:</b>  <b>INITIAL CREDENTIALING:</b>  LEGIBILITY: A SECOND SURVEYOR EXAMINES ANY RECORD JUDGED TO BE ILLEGIBLE	0*							
PATIENT IDENTIFICATION	1							
HISTORY	1							
ALLERGIES (Prominently displayed such as: inside cover and on medication sheet)	1							
ALL ENTRIES SIGNED AND DATED IN INK FOLLOWED BY THE TITLE OF RECORDER	1							
<b>VISITS:</b>  -CHIEF COMPLAINT/REASON FOR VISIT -OBJECTIVE FINDINGS -DIAGNOSIS OR IMPRESSION -PLAN -PRESCRIPTIONS -IMMUNIZATIONS	1							
<b>STUDIES ORDERED:</b>  -TYPE -REASON -RESULTS -PATIENT NOTIFIED OF NEGATIVE FINDINGS	1							
<b>REFERRALS/THERAPIES ORDERED</b>  -SPECIALTY/TYPE -REASON -RESULTS	1							

\* LEGIBILITY: IF RESPONSE IS NO, STOP REVIEW; NO POINTS WILL BE GIVEN FOR THAT RECORD.

\*\* ADD ALL Y OR N/A RESPONSES PER LINE.

IF APPLICABLE, SUBTOTAL POINTS – PAGE 4 \_\_\_\_\_

**EXHIBIT A  
RE-CREDENTIALING REVIEW**

**PROVIDER**

**IF THE AREA NURSE CERTIFIES THAT A SATISFACTORY MEDICAL RECORD REVIEW WAS COMPLETED IN THE 6 MONTHS PRIOR TO THE RE-CREDENTIALING DATE, THE RE-CREDENTIALING REVIEW MAY BE ELIMINATED AND THE PROVIDER MAY BE AWARDED 40 POINTS**

STANDARDS	POINTS PER FILE	FINDINGS – ENTER Y, N OR N/A					TOTAL POINTS**	COMMENTS
		1	2	3	4	5		
<b>MEDICAL RECORDS CONTAIN DOCUMENTATION OF ATTEMPTS TO COMPLY WITH THE FOLLOWING:</b> <b>RE-CREDENTIALING*</b>	2							
-MEDICAL RECORDS FROM PREVIOUS PROVIDERS	2							
-CHILDHOOD IMMUNIZATIONS	2							
-HEALTH SCREENINGS	2							
-REFERRAL AND/OR CONSULTANT REPORTS	2							
-ANY IDENTIFIED PROBLEM AREAS IN MEDICAL RECORDS FROM PREVIOUS VISIT	0***							

STANDARDS	POINTS	YES	NO	CRITERIA	COMMENTS
<b>OUTREACH</b>					
-OUTREACH TO NEWLY ASSIGNED PATIENTS	10	Y	N	Office has documented at least two attempts to contact newly assigned patients within 3 months of enrollment.	
-OUTREACH TO PATIENTS MORE THAN 3 MONTHS BEHIND IN SCREENINGS	10	Y	N	Office can demonstrate outreach efforts to established patients.	

STANDARDS	YES	NO	COMMENTS
<b>ADD'L INFO TO BE OBTAINED ON RE-CREDENTIALING VISIT</b>			
MEMBER RIGHTS POSTED	Y	N	
MEMBER COMPLAINT PROCEDURES POSTED	Y	N	
MEDIPASS AREA OFFICE PHONE NUMBER POSTED	Y	N	

\* IF MAJOR PROBLEMS ARE NOTED, COMPLETE THE CREDENTIALING REVIEW WITH A PROVISIONAL RECOMMENDATION AND REQUEST THAT A FULL MEDICAL RECORD REVIEW BE SCHEDULED.

\*\* ADD ALL Y OR N/A RESPONSES PER LINE AND MULTIPLY BY 2.

\*\*\* NO POINTS ARE AWARDED BUT A DEFICIENCY IN THIS AREA MAY RESULT IN A RECOMMENDATION FOR PROVISIONAL CERTIFICATION OR TERMINATION

**IF APPLICABLE, SUBTOTAL POINTS – PAGE 5 \_\_\_\_\_**

EXHIBIT A

PROVIDER \_\_\_\_\_

**SITE SURVEY RECOMMENDATION\*(CIRCLE ONE RESPONSE): YES NO PROVISIONAL**

**GENERAL COMMENTS** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**NAME OF SURVEYOR SIGNATURE OF SURVEYOR DATE**  
**CREDENTIALING RECOMMENDATION \*(CIRCLE ONE RESPONSE): YES NO PROVISIONAL**

**GENERAL COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**NAME OF COORDINATOR SIGNATURE OF COORDINATOR DATE**

\* NO OR PROVISIONAL REQUIRES EXPLANATION UNDER COMMENTS.  
 POINTS:

**PAGE 1** \_\_\_\_\_  
**PAGE 2** \_\_\_\_\_  
**PAGE 3** \_\_\_\_\_  
**PAGE 4** \_\_\_\_\_  
 OR  
**PAGE 5** \_\_\_\_\_

<b>ACCEPTABLE</b>	<b>75 – 100**</b>
<b>UNACCEPTABLE</b>	<b>UNDER 75***</b>

**TOTAL POINTS** \_\_\_\_\_

\*\* IF AN AREA DOES NOT CHOOSE TO RECOMMEND A PCP WITH A SCORE EQUAL TO OR GREATER THAN 75, A DETAILED EXPLANATION MUST BE GIVEN UNDER COMMENTS.

- \*\*\* 1) IF AN AREA WISHES TO RECOMMEND A PCP WITH A SCORE BELOW 75, A DETAILED EXPLANATION MUST BE GIVEN UNDER COMMENTS. ONE SUCH EXAMPLE MAY BE ON A RECREDENTIALING VISIT WHEN THE PCP HAS LIMITED HIS/HER PARTICIPATION TO 2 OR 3 MEDIPASS PATIENTS.  
 2) IF THE SCORE FALLS BELOW 75, THE AREA MAY RECOMMEND PROVISIONAL STATUS IN ORDER TO ALLOW THE PROVIDER AN OPPORTUNITY TO IMPROVE. A FOLLOW-UP SITE VISIT MUST BE SCHEDULED WITHIN 3 TO 6 MONTHS.