



BUREAU OF MANAGED HEALTH CARE
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**INTERPRETIVE GUIDELINES FOR INITIAL HEALTH CARE PROVIDER
CERTIFICATES**

**HEALTH MAINTENANCE ORGANIZATIONS
AND PREPAID HEALTH CLINICS**

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Note: Statute and rule in the interpretive guidelines are included for informational purposes. Florida Statute and Administrative Code should be referenced for the complete text.

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STANDARD	INTERPRETIVE GUIDELINES	SURVEYOR PROBES
<p><u>HMO 1</u></p> <p><u>GOVERNING BODY</u></p> <p>Each HMO or PHC shall have a governing body that sets policy and has overall responsibility for the organization including the following:</p> <p>Adopting organizational bylaws, rules, and regulations or similar form of document, which provides a clear concise statement of the mission, goals, and objectives of the organization.</p> <p>59A-12.004(1)(a), F.A.C.</p>	<p>The governing body has overall responsibility for setting policies, which provide the framework for operation of the organization.</p> <p>These policies shall be in writing and signed by members of the governing body, representatives of the organization, and the medical director.</p> <p>The organizational bylaws or similar form of document provides the structure, purpose, and philosophy of the organization regarding quality of care to subscribers.</p>	<p>Review organizational bylaws for:</p> <ol style="list-style-type: none"> 1. Mission statement, goals, and objectives of the organization. 2. Reference to scope of services: geographic area served, medical services, and staffing plan. 3. Establishment and support of committees (including type, membership composition, and frequency of meetings) which monitor and enforce the provisions of quality of care.
<p><u>HMO 2</u></p> <p><u>GOVERNING BODY</u></p> <p>Adopting a quality assurance program that monitors the key areas of health care delivery to identify problems and insure the early recognition of opportunities to improve the delivery of quality health care services.</p> <p>59A-12.004(1)(b), F.A.C.</p>	<p>Accountability in the area of quality of care will be addressed by the governing body's provisions for adoption of a quality assurance program of internal systems review and monitoring, a medical credentialing program, and establishment of a management system that clearly delineates authority, responsibilities, functions, and chain of command.</p>	<p>Review bylaws for documentation that the governing body has adopted a quality assurance program with the goal of delivering quality health care to subscribers.</p> <p>Review quality assurance committee minutes for reference to adoption of a quality assurance program that is consistent with the philosophy and goals of the governing body.</p> <p>Review peer review for adherence to quality of care standards established by the governing body.</p> <p>Review guidelines as established by the governing body for the ongoing evaluation of quality of care delivery.</p> <ol style="list-style-type: none"> 1. Quality assurance studies. 2. Quality assurance monitors.

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		<p>3. External review process of the internal quality assurance program.</p> <p>Review quality assurance committee minutes for documentation that quality assurance activities are reported to the governing body and reviewed by the medical director.</p> <p>Review governing body minutes for documentation that the governing body is aware of and takes action on quality assurance activities as appropriate on an ongoing basis.</p>
<p><u>HMO 3</u></p> <p><u>GOVERNING BODY</u></p> <p>Maintaining the ultimate responsibility for ongoing quality assurance, risk management programs, and credentialing programs.</p> <p>59A-12.004(1)(c), F.A.C.</p>	<p>Accountability in the area of quality of care will be addressed by the governing body's provisions for adoption of a quality assurance program of internal systems review and monitoring, a medical credentialing program, and establishment of a management system that clearly delineates authority, responsibilities, functions, and chain of command.</p>	<p>Review bylaws for documentation that the governing body maintains the ultimate responsibility for ongoing quality assurance and credentialing programs.</p> <p>Review bylaws for documentation that the governing body has adopted a credentialing program that provides criteria for initial selection and ongoing maintenance of a body of qualified health care providers.</p> <p>Review minutes of credentialing committee for documentation that credentialing activities are reported to the governing body.</p> <p>Review governing body minutes for documentation that the governing body is aware of, and takes action on credentialing activities as appropriate on an ongoing basis.</p>

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<p><u>HMO 4</u></p> <p><u>GOVERNING BODY</u></p> <p>The relationship between management and the governing body shall be set forth in writing including each person's authority, responsibilities, and functions.</p> <p>59A-12.004(2), F.A.C.</p>	<p>Accountability in the area of quality of care will be addressed by the governing body's provisions for adoption of a quality assurance program of internal systems review and monitoring, a medical credentialing program, and establishment of a management system that clearly delineates authority, responsibilities, functions, and chain of command.</p> <p>Nothing in this rule shall prohibit the designation of qualified management personnel to implement the provisions of subsection (1) and to manage the operation of the HMO or PHC in the geographic area or areas serviced.</p> <p>59A-12.004(2), F.A.C.</p>	<p>Review bylaws for:</p> <ol style="list-style-type: none"> 1. Documentation that the relationship between management personnel and the governing body, including authority, responsibilities and functions, is in writing. 2. Written standards of mutual accountability between the governing body and management personnel. <p>Verify the presence of written job descriptions for all management personnel to verify consistency with standards established by the governing body.</p> <p>Review the organizational chart to verify clearly defined chain of command and lines of authority.</p>
<p><u>HMO 5</u></p> <p><u>MEDICAL RECORDS</u></p> <p>Each HMO or PHC shall maintain or assure its providers maintain a medical records system which is consistent with professional standards and which:</p> <p style="padding-left: 40px;">Permits prompt retrieval of information and provides legible and timely information accurately documented and readily available to appropriate or authorized health care practitioners.</p> <p>59A-12.005(1), F.A.C.</p>	<p>Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of or administers a department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any person shall, upon request of such person or the person's legal representative, furnish, in a timely manner, without delays for legal review, copies of all reports and records relating to such examination or treatment, including x rays, and insurance information. However, when a patient's psychiatric, chapter 490 psychological or chapter 491 psychotherapeutic</p>	<p>Review medical records policies and procedures for documentation of a written policy and clearly defined procedures for:</p> <ol style="list-style-type: none"> 1. Internal retrieval of records. 2. Transfer and retrieval of records among physicians and between the the organization's administrative offices and its providers. <p>Examine educational documents for verification that a system has been developed for providing in-service education for specialty and primary physicians and their staff and the organization's internal staff regarding the organization's medical records system to</p>

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	<p>records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon the patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered. s. 456.057(4), F.S.</p> <p>Except as otherwise provided in this section and in s. 440.13(4)(c), such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient's legal representative or other health care practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient. s. 456.057(5), F.S.</p>	<p>include:</p> <ol style="list-style-type: none"> 1. Transfer of records. 2. Accessing records. 3. Standardized clinical record forms to be used if applicable. 4. Required patient information. 5. Person in charge of coordinating the transfer of records.
<p><u>HMO 6</u></p> <p><u>MEDICAL RECORDS</u></p> <p>Protects the confidentiality of patient records.</p> <p>59A-12.005(2), F.A.C.</p>	<p>Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of or administers a department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any person shall, upon request of such person or the person's legal representative, furnish, in a timely manner, without delays for legal review, copies of all reports and records relating to such examination or treatment, including x rays, and insurance information. However, when a patient's psychiatric, chapter 490 psychological or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner</p>	<p>Review medical records policy and procedures for documentation that the organization has a written policy and clearly defined procedures for protecting confidentiality of patient records in transfer and storage.</p> <p>Verify that a system for release of medical records has been developed which includes forms to be signed by the patient to release all or part of the medical records.</p> <p>Verify that a system to ensure consistency among primary and specialty physicians' offices and clinics regarding confidentiality of records as mandated by the organization has been established.</p>

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	<p>may provide a report of examination and treatment in lieu of copies of records. Upon the patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered. s. 456.057(4), F.S.</p> <p>Except as otherwise provided in this section and in s. 440.13(4)(c), such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient's legal representative or other health care practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient. s. 456.057(5), F.S.</p>	<p>Review provider contracts for reference to maintaining confidentiality of member records/information.</p> <p>Review the documentation of site visits of provider offices by the Plan to determine if organizational policies and procedures for protecting the confidentiality of patient records are being followed. (Select a random sample of site visit audits.)</p> <p>Verify that a system has been developed for providing in-service education for primary and specialty physicians and their staff and the organization's internal staff regarding protection of confidentiality of patient records and release of records.</p>
<p><u>HMO 7</u></p> <p><u>MEDICAL RECORDS</u></p> <p>A health maintenance organization or prepaid health clinic, as defined in this chapter, must maintain strict confidentiality against unauthorized or inadvertent disclosure of confidential information to persons inside or outside the health maintenance organization or prepaid health clinic regarding psychotherapeutic services provided to subscribers by psychotherapists licensed under chapter 490 or chapter 491 and psychotherapeutic records and reports related to the services.</p> <p>s. 641.59, F.S.</p>	<p>Any health care practitioner licensed by the department or a board within the department who makes a physical or mental examination of or administers a department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any person shall, upon request of such person or the person's legal representative, furnish, in a timely manner, without delays for legal review, copies of all reports and records relating to such examination or treatment, including x rays, and insurance information. However, when a patient's psychiatric, chapter 490 psychological or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon the patient's</p>	<p>Review policies and procedures of the organization for the handling and the release of information regarding psychotherapeutic services provided to subscribers both inside and outside the organization.</p> <p>Review forms developed by the organization for requesting the release of information regarding psychotherapeutic services provided to subscribers.</p> <p>Review the provider manual for policies and procedures of the organization for the handling and the release of information and maintaining strict confidentiality regarding psychotherapeutic services provided to subscribers both inside and outside the organization.</p>

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	<p>written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered. s.456.057(4), F.S.</p> <p>Except as otherwise provided in this section and in s.440.3 (4)(c), such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient's legal representative or other health care practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient. s. 456.057(5), F.S.</p>	
<p><u>HMO 8</u></p> <p><u>MEDICAL RECORDS</u></p> <p>Identifies the patient as follows: (a) Name; (b) Member identification number; (c) Date of birth; and (d) Sex.</p> <p>59A-12.005(4), F.A.C.</p>	<p>(When performing medical record reviews, review a representative sample of 50 medical records of individual subscribers. When selecting a sample, any and all medical records may be subject to review. The sample of medical records shall be representative of all subscribers' records.)</p>	<p>Review medical records policies and procedures for a written policy has been established requiring name, member identification number, date of birth, and sex to be included in every subscriber's medical record.</p> <p>Verify that a method for obtaining the required patient identification information is being utilized:</p> <ol style="list-style-type: none"> 1. Patient data sheet. 2. Demographic chart. <p>Review a random sample of patient records to verify that the required patient identification information is present and consistent throughout the medical record.</p>
<p><u>HMO 9</u></p> <p><u>MEDICAL RECORDS</u></p>		

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<p>Records in the medical record a summary of significant surgical procedures, past and current diagnoses or problems and allergies and untoward reactions to drugs and current medications.</p> <p>59A-12.005(3), F.A.C.</p>	<p>(When performing medical record reviews, review a representative sample of 50 medical records of individual subscribers. When selecting a sample, any and all medical records may be subject to review. The sample of medical records shall be representative of all subscribers' records.)</p>	<p>Review the medical records policies and procedures for documentation that:</p> <ol style="list-style-type: none"> 1. The organization has a written policy requiring a summary report which includes significant surgical procedures, diagnoses or problems, and allergies and untoward reactions to drugs to be a part of every subscriber's medical record. 2. A written policy and clearly defined procedures have been established for making pertinent information obtained from referral sources part of the subscriber's medical record. 3. The organization has adopted standards for completeness, accuracy, consistency, and currentness of patient's clinical information. <p>Verify that a method for obtaining complete and current patient clinical information and maintaining an updated summary is being utilized among health providers. For example:</p> <ol style="list-style-type: none"> 1. History and physical form. 2. Summary sheet. 3. Checklist.
<p><u>HMO 10</u></p> <p><u>MEDICAL RECORDS</u></p> <p>Indicates in the medical record for each visit the following information as appropriate:</p> <ol style="list-style-type: none"> (a) Date; (b) Chief complaint or purpose of visit; (c) Objective findings of practitioner; (d) Diagnosis or medical impression; (e) Studies ordered, for example: lab, x-ray, EKG; and referral reports; (f) Therapies administered and prescribed; (g) Name and profession of practitioner rendering 	<p>(When performing medical record reviews, review a representative sample of 50 medical records of individual subscribers. When selecting a sample, any and all medical records may be subject to review. The sample of medical records shall be representative of all subscribers' records.)</p>	<p>Review medical records policy and procedures for :</p> <ol style="list-style-type: none"> 1) Documentation of a written policy requiring that the date, chief complaint or purpose of visit, diagnosis or medical impression of practitioner, disposition, recommendations, follow-up, and outcome of services be recorded in the patient record for each visit. 2) Established procedures for recording the required information for each visit accurately and completely.

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<p>services, for example: M.D., D.O., D.C., D.P.M., R.N., O.D., etc., including signature or initials of practitioner;</p> <p>(h) Disposition, recommendations, instructions to the patient and evidence of whether there was follow-up; and</p> <p>(i) Outcome of services.</p> <p>59A-12.005(5), F.A.C.</p>		<p>a) Patient assessment forms.</p> <p>b) Checklist.</p> <p>3) Documentation that a written policy requiring physician co-signature for entries made by a nurse practitioner, physician’s assistant, etc. in the patient record has been adopted.</p> <p>4) Documentation that a written policy regarding follow-up care and written procedures for recording results of studies and therapies and appropriate follow-up have been adopted.</p>
<p><u>HMO 11</u></p> <p><u>ADVANCED DIRECTIVES</u></p> <p>The facility’s policy shall include providing each adult individual, at the time of enrollment of the individual with the organization, with written information concerning the health facility’ policies respecting advanced directives;</p> <p>59A-12.013(2)(b), F.A.C.</p>	<p>Each health maintenance organization shall have written policies and procedures that delineate the health care facility’s position with respect to the state law and rules relative to advance directives. The policies shall not condition treatment or admission upon whether or not the individual has executed or waived an advance directive. In the event of conflict between the facility’s policies and procedures and the individual’s advance directive, provision should be made in accordance with section 765.1105, Florida Statutes.</p> <p>59A-12.013(1), F.A.C.</p>	<p>Review policies and procedures of the Plan for providing information regarding advanced directives to subscribers at the time of enrollment.</p> <p>Review the member handbook and enrollment materials for information regarding the subscriber’s right to file an advanced directive.</p>
<p><u>HMO 12</u></p> <p><u>MEDICAL RECORDS</u></p> <p>The policy shall include the requirement that documentation of the existence of an advanced directive be</p>		<p>Review policies and procedures of the Plan regarding advanced directives.</p>

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<p>contained in the medical record. A health care facility which is provided with the individual's advanced directive shall make the advanced directive or a copy thereof a part of the individual's medical record.</p> <p>59A-12.013(2)(c), F.A.C.</p>		<p>Review medical record policies and procedures regarding the requirement for documentation of whether an advanced directive exists and that if the member chooses to have an advanced directive, that the advanced directive or a copy of the advanced directive shall be made a part of the member's medical record if the health care facility has been provided a copy.</p> <p>Review the medical record audit tool and medical record audits of applicable provider sites for monitoring for documentation of whether an advanced directive exists, and if it does, that the advanced directive or a copy thereof is a part of the member's medical record if the health care facility has been provided a copy.</p> <p>Review the provider manual for policies and procedures of the organization regarding advanced directives and medical record policies and procedures regarding advanced directives.</p>
<p><u>HMO 13</u></p> <p><u>MEDICAL RECORDS</u></p> <p>The HMO or PHC administrator shall be responsible for requesting consent of subscribers for release of medical records and for obtaining all documents and medical records from contracted providers necessary to carry out the provisions of Chapter 641, Part III, F.S., and Chapter 59A-12, F.A.C.</p> <p>59A-12.005(6), F.A.C.</p>		<p>Review policies and procedures of the organization for requesting consent of subscribers for release of medical records.</p> <p>Review forms used by the organization for requesting consent of subscribers for releasing medical records.</p> <p>Review site visit audits of contracted provider offices for monitoring of existence of policies and procedures regarding release of medical records.</p> <p>Review the provider manual and provider contracts</p>

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<p><u>HMO 14</u></p> <p><u>QUALITY OF CARE</u></p> <p>Each HMO or PHC shall: Make available to each member an appropriate health assessment in accordance with preventive health guidelines and professional standards in the community.</p> <p>59A-12.006(1), F.A.C.</p>	<p>Minimum services include the following: Preventive Health Care Services. A program of health evaluation, education, and immunizations, which is designed to prevent illness and disease and to improve the general health of HMO or PHC subscribers. This program shall include at least the following:</p> <ol style="list-style-type: none"> 1. Well-child care from birth; 2. Periodic health evaluations for adults; 3. Eye and ear screenings by a physician for children through age 17 to determine the need for vision or hearing correction; and 4. Pediatric and adult immunizations, in accord with accepted medical practice. <p>59A-12.002(6)(e), F.A.C.</p>	<p>for provisions regarding the release of medical records.</p> <p>Review policies and procedures for documentation that criteria for health assessments have been adopted.</p> <p>Review the member handbook and literature provided to the member at the time of enrollment for information regarding the availability of a health assessment.</p> <p>Examine health education materials to be used for patient teaching for verification of availability, variety, and appropriateness.</p>
<p><u>HMO 15</u></p> <p><u>QUALITY OF CARE</u></p> <p>Each organization shall allow, without prior authorization, a female subscriber, to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary follow up care detected at that visit. Nothing in this subsection shall prevent an organization from requiring that an obstetrician/gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.</p> <p>s.641.51(11),F.S.</p>		<p>Review for documentation that policies and procedures have been adopted.</p> <p>Review the member handbook and literature provided to the member at the time of enrollment for information regarding the availability of one annual obstetrician/gynecologist visit and for medically necessary follow up care detected at that visit without prior authorization.</p> <p>Examine health education materials to be used for</p>

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		patient teaching for verification of availability, variety, and appropriateness.
<p><u>HMO 16</u></p> <p><u>QUALITY OF CARE</u></p> <p>Each organization shall adopt recommendations for preventive pediatric health care which are consistent with the requirements for health checkups for children developed for the Medicaid Program.</p> <p>s. 641.51(10), F.S.</p>	<p>Previously known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), this program requirement is currently known as the “Child Health Check-Up” under the Agency for Health Care Administration. Specific requirements under this program may be found on the internet at www.fdhc.state.fl.us under Medicaid; provider handbooks.</p> <p>All health maintenance contracts that provide coverage, benefits, or services for a member of the family of the subscriber must, as to such family member’s coverage, benefits, or services, also provide that the benefits applicable for children include coverage for child health supervision services from the moment of birth to age 16 years. s.641.31(30)(a),F.S.</p> <p>Child health supervision services must include periodic visits that shall include a history, a physical exam, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics. s.641.31(30)(b)(1),F.S.</p>	
<p><u>HMO 17</u></p>		

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<p><u>QUALITY OF CARE</u></p> <p>Each HMO or PHC shall provide for or arrange the following services as a minimum:</p> <p>(a) Coordination of all necessary care contracted for with the subscriber;</p> <p>(b) Acute episodic care, with appropriate ancillary services necessary for proper evaluation and treatment, for example:</p> <ol style="list-style-type: none"> 1. Laboratory studies; 2. Diagnostic radiology; 3. Treatment plan, and 4. Specialty consultation referrals. <p>(c) Chronic disease screening, and follow-up treatment for prevention of complications, for example:</p> <ol style="list-style-type: none"> 1. Periodic update of history and physical examination; 2. Hypertension follow-up; 3. Diabetes follow-up. <p>(d) Health risk appraisal and prevention measures, for example:</p> <ol style="list-style-type: none"> 1. Dietary counseling; 2. Smoking cessation education; 3. Stress reduction counseling, and 4. Substance abuse education. <p>(e) Family planning services.</p> <p>59A-12.006(2), F.A.C.</p>	<p>Every health maintenance contract, certificate, or member handbook shall clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity which is underwriting any of the services offered by the health maintenance organization. The contract, certificate, or member handbook shall also state where and in what manner the comprehensive health care services may be obtained.</p> <p>s. 641.31(4), F.S.</p> <p>“Minimum services” includes any of the following: emergency care, inpatient hospital services, physician care, ambulatory diagnostic treatment, and preventative health care services.</p> <p>s.641.47(12),F.S.</p> <p>Each health maintenance organization and prepaid health plan shall provide coverage for all medically appropriate and necessary equipment, supplies, and services used to treat diabetes, including outpatient self-management training and educational services, if the patient’s primary care physician, or the physician to whom the patient has been referred who specializes in treating diabetes, certifies that the equipment, supplies, or services are necessary.</p> <p>s. 641.31(26)(a), F.S.</p> <p>Every health maintenance contract issued or renewed on or after January 1, 1996, shall provide coverage for at least the following:</p> <p>(a) A baseline mammogram for any woman who is</p>	<p>Review policies and procedure for documentation that a written policy and procedure has been written for:</p> <ol style="list-style-type: none"> 1. Coordination, evaluation, and treatment of acute medical problems and conditions; 2. Chronic disease screening and follow-up; 3. Health risk appraisal and prevention measures. <p>Review health education materials to be used for patient teaching for verification of availability, variety, and appropriateness.</p>

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	<p>35 years of age or older, but younger than 40 years of age.</p> <p>(b) A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendations.</p> <p>(c) A mammogram every year for any woman who is 50 years of age or older.</p> <p>(d) One or more mammograms a year, based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of thirty.</p> <p>s. 641.31095(1)(a)(b)(c)(d), F.S.</p> <p>The coverage, benefits, or services for newborn children must consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending physician as medically necessary to protect the health and safety of the newborn child.</p> <p>s.641.31(9),F.S.</p> <p>The initial procedure for screening the hearing of the newborn or infant and any medically necessary follow-up reevaluations leading to diagnosis shall be a covered benefit. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(30), Florida Statutes, except for supplemental policies that only provide coverage for specific diseases,</p>	<p>Review policies and procedures for provision for the coordination of care and coverage for the initial procedure for screening the hearing of the newborn or infant and any medically necessary follow-up reevaluations leading to diagnosis.</p> <p>Review the provider manual for policies and procedures for providing coordination of care for the initial procedure for screening the hearing of the newborn or infant and any medically necessary follow-up reevaluations leading to diagnosis.</p>

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	<p>hospital indemnity, or Medicare supplement, or to the supplemental policies, shall compensate providers for the covered benefit at the contracted rate. Laws of Florida – HB 399(3)(j) [Effective date 7/01/00]</p> <p>A health maintenance contract that covers a child under the age of 18 must provide coverage for treatment of cleft lip and cleft palate for the child. s. 641.31(35), F.S.</p> <p>All health maintenance contracts that provide coverage for massage must also cover the services of persons licensed to practice massage pursuant to chapter 480 if the massage is prescribed by a contracted physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 as medically necessary and the prescription specifies the number of treatments. s. 641.31(37), F.S.</p> <p>“Dental treatment or surgery shall be considered necessary when the dental condition is likely to result in a medical condition if left untreated...” s 641.31(34), F.S.</p> <p>A health maintenance organization that meets the requirements of paragraph (b) may, through a point-of-service rider to its contract providing comprehensive health care services, include a point-of-service benefit. Under such a rider, a subscriber or other covered person of the health maintenance organization <u>may</u> choose, at the time of covered service, a provider with whom the health maintenance organization does not have a health maintenance organization provider contract. s.641.31(38)(a),F.S.</p>	

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	<p>A health maintenance organization contract may not prohibit or restrict a subscriber from receiving inpatient services in a contracted hospital from a contracted primary care or admitting physician if such services are determined by the organization to be medically necessary and covered services under the organization’s contract with the contract holder. s. 641.31(39), F.S.</p> <p>A contract between a health maintenance organization and a primary care or admitting physician may not contain any provision that prohibits such physician from providing inpatient services in a contracted hospital to a subscriber if such services are determined by the organization to be medically necessary and covered under the organization’s contract with the contract holder. s. 641.315(11), F.S.</p> <p>A health maintenance organization shall pay a contracted primary care or admitting physician, pursuant to such physician’s contract, for providing inpatient services in a contracted hospital to a subscriber, if such services are determined by the organization to be medically necessary and covered services under the organization’s contract with the contract holder. s.641.3155(5), F.S.</p>	
<p><u>HMO 18</u></p> <p><u>QUALITY OF CARE</u></p> <p>Each HMO or PHC shall ensure that the health care services it provides or arranges for are accessible to the subscriber with reasonable promptness. Such services include at a minimum: Establishment of an appointment system.</p>		<p>Review policy and procedures for documentation that a policy regarding accessibility of services has been established.</p> <p>Review provider site visit audits, provider applications, and/or similar forms of documentation</p>

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59A-12.006(3)(a), F.A.C.		<p>for evidence of the establishment of an appointment system that provides access to health care professionals with minimal wait.</p> <p>Review the member handbook for instructions given to the member regarding an appointment system.</p>
<p><u>HMO 19</u></p> <p><u>QUALITY OF CARE</u></p> <p>A provision that patients with appointments have a professional evaluation within one hour of scheduled appointment time. If a delay is unavoidable, the patient shall be informed and provided an alternative.</p> <p>59A-12.006(3)(c), F.A.C.</p>		<p>Review policy and procedures for documentation that a policy regarding timely medical evaluation has been established.</p> <p>Review the provider manual for a policy regarding timely medical evaluation has been conveyed to providers.</p>
<p><u>HMO 20</u></p> <p><u>QUALITY OF CARE</u></p> <p>A method to distinguish among emergency, urgent, and routine cases.</p> <ol style="list-style-type: none"> 1. Emergencies will be seen immediately; 2. Urgent cases will be seen within 24 hours; 3. Routine symptomatic cases will be seen within two weeks; 4. Routine non-symptomatic cases will be seen as soon as possible. <p>59A-12.006(3)(b), F.A.C.</p>		<p>Review policy and procedures for documentation that a policy regarding accessibility of services has been established to distinguish between emergency, urgent, and routine symptomatic and non-symptomatic cases.</p> <p>Review policy and procedures for verification that procedures have been established for distinguishing between and scheduling appointments for emergency, urgent, and routine symptomatic and non-symptomatic cases.</p> <p>Review the provider manual to verify that policies and procedures regarding time frames for emergency, urgent, routine symptomatic, and routine non</p>

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		symptomatic cases have been included.
<p><u>HMO 21</u></p> <p><u>QUALITY OF CARE</u></p> <p>Average travel time from the HMO geographic service area boundary to the nearest general hospital under arrangement with the HMO to provide health care services is no longer than 30 minutes under normal circumstances. Average travel time from the HMO geographic services area boundary to the nearest provider of specialty physician services, ancillary services, specialty inpatient hospital services and all other health services of no longer than 60 minutes under normal circumstances. AHCA shall waive this requirement if the HMO provides sufficient justification as to why the average travel time requirement is not feasible or necessary in a particular geographic service area.</p> <p>59A-12.006(3)(d), F.A.C.</p>	<p>Health maintenance contracts which provide coverage, benefits, or services for maternity care shall provide, as an option to the subscriber, the services of nurse midwives and midwives, licensed pursuant to chapter 467, and the services of birth centers licensed pursuant to ss. 383.30-383.335, if such services are available within the service area. s. 641.31(18)(a) F.S.</p> <p>“Geographic area” means the county or counties, or any portion of a county or counties, within which the health maintenance organization provides or arranges for comprehensive health care services to be available to its subscribers. s. 641.47(9), F.S.</p>	<p>Review policy and procedures for a policy regarding accessibility of services has been established.</p> <p>Verify that the average travel time from the HMO geographic services area boundary to the nearest primary care delivery site or nearest general hospital under arrangement with the HMO to provide health care services is no longer than 30 minutes, and the average travel time from the HMO geographic services area boundary to the nearest provider of specialty physician services, specialty inpatient hospital services and all other health services is no longer than 60 minutes under normal circumstances.</p> <ol style="list-style-type: none"> 1) Use county maps to compare county boundary lines to sites. 2) Verify adequate availability of contracted physicians with hospital privileges at contracted hospitals through review of credential files and the provider directory and/or lists of providers.
<p><u>HMO 22</u></p> <p><u>QUALITY OF CARE</u></p> <p>Provision of</p> <ol style="list-style-type: none"> 1. accessible hours of operation and 2. after hours emergency services 		<p>Review policy and procedures for a written policy regarding provision of accessible hours of operation and after hour’s emergency services and urgent care.</p>

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59A-12.006(3)(e)		<p>Review organizational brochures, member handbook, or similar documents for information provided to subscribers regarding hours of operation and after hours emergency services.</p> <p>Review the organization’s method of monitoring private physicians’ office hours for verification of accessibility of hours and emergency services for Plan members.</p>
<p><u>HMO 23</u></p> <p><u>QUALITY OF CARE</u></p> <p>Chronic diseases among subscriber populations. Each organization must:</p> <ol style="list-style-type: none"> (1) Annually study its subscriber population to determine the most prevalent chronic diseases of its subscribers, design intervention strategies to reduce the morbidities and mortalities associated with at least two prevalent chronic diseases, measure the outcomes of the interventions implemented, and modify the interventions, if necessary, to improve their effectiveness. (2) Request the input and assistance of its providers and share the information developed under subsection (1) with its providers, and (3) Share the information developed under subsections (1) and (2) with subscribers identified as having these chronic diseases. <p>s. 641.62, F.S.</p>	<p>Each organization shall release to the agency data that are indicators of access and quality of care. The agency shall develop rules specifying data reporting requirements for these indicators. The indicators shall include the following characteristics;</p> <ol style="list-style-type: none"> (a) They must relate to access and quality of care measures.. (b) They must be consistent with data collected pursuant to accreditation activities and standards. (c) They must be consistent with frequency requirements under the accreditation process. (d) They must include measures of the management of chronic diseases. (e) They must include preventative health care for adults and children. (f) They must include measures of prenatal care. (g) They must include measures of health checkups for children. <p>s. 641.51(9),F.S.</p>	<p>Review Quality Improvement Plan for studies of the subscriber population regarding the most prevalent chronic diseases of its subscribers and intervention strategies related to at least two prevalent chronic diseases of the subscriber population.</p>
<p><u>HMO 24</u></p> <p><u>EMERGENCY SERVICES</u></p>		

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<p>When a subscriber is present at a hospital seeking emergency services and care, the determination as to whether an emergency medical condition, as defined in s.641.47 exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician.</p> <p>The physician or the appropriate personnel shall indicate in the patient’s chart the results of the screening, examination, and evaluation. The health maintenance organization shall compensate the provider for the screening, evaluation, and examination that is reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient’s condition is an emergency medical condition. The health maintenance organization shall compensate the provider for emergency services and care. If a determination is made that an emergency medical condition does not exist, payment for services rendered subsequent to that determination is governed by the contract under which the subscriber is covered.</p> <p>s. 641.513(3)(a), F.S.</p>	<p>“Emergency medical condition” means:</p> <p>(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:</p> <ol style="list-style-type: none"> 1) Serious jeopardy to the health of a patient, including a pregnant woman or a fetus. 2) Serious impairment to bodily functions. 3) Serious dysfunction of any bodily organ or part. <p>(b) With respect to a pregnant woman:</p> <ol style="list-style-type: none"> 1) That there is inadequate time to effect safe transfer to another hospital prior to delivery; 2) That a transfer may pose a threat to the health and safety of the patient or fetus; or 3) That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes. <p>s. 641.47(7)(a)(b), F.S.</p> <p>“Emergency services and care” means 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.</p> <p>s. 641.47(8), F.S.</p> <p>If a determination has been made that an emergency medical condition exists and the subscriber has notified the hospital, or the hospital emergency personnel otherwise have knowledge that the patient is a subscriber of a health maintenance</p>	<p>Review policies and procedures regarding emergency services and the provision of these services for subscribers.</p> <p>Review the member handbook for a clear description of how to access emergency services.</p> <p>Review the member card for instructions for the subscriber of how to access emergency services and that these instructions are consistent with policies and procedures and instructions in the subscriber agreement and member handbook.</p> <p>Review the provider manual for policies and procedures regarding emergency services.</p>

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	<p>organization, the hospital must make reasonable attempt to notify the subscriber's primary care physician, if known, or the health maintenance organization, if the health maintenance organization had previously requested in writing that the notification be made directly to the health maintenance organization, of the existence of the emergency medical condition. If the primary care physician is not known, or has not been contacted, the hospital must:</p> <ol style="list-style-type: none"> 1. Notify the health maintenance organization as soon as possible prior to discharge of the subscriber from the emergency care area; or 2. Notify the health maintenance organization within 24 hours or on the next business day after admission of the subscriber as an inpatient to the hospital. <p>If notification required by this paragraph is not accomplished, the hospital must document its attempts to notify the health maintenance organization of the circumstances that precluded attempts to notify the health maintenance organization. A health maintenance organization may not deny payment for emergency services and care based on a hospital's failure to comply with the notification requirements of this paragraph. Nothing in this paragraph shall alter any contractual responsibility of a subscriber to make contact with the health maintenance organization, subsequent to receiving treatment for the emergency medical condition.</p> <p>s. 641.513(3)(b), F.S.</p> <p>If the subscriber's primary care physician responds to the notification, the hospital physician and the primary care physician may discuss the appropriate care and treatment of the subscriber. The health maintenance organization may have a member of</p>	

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	<p>the hospital staff with whom it has a contract participate in the treatment of the subscriber within the scope of the physician's hospital staff privileges. The subscriber may be transferred, in accordance with state and federal law, to a hospital that has a contract with the health maintenance organization and has the service capability to treat the subscriber' emergency medical condition. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient in accordance with federal law, which is necessary to determine if the patient is a subscriber of a health maintenance organization, if emergency services and care are not delayed.</p> <p>s. 641.513(3)(c), F.S.</p>	
<p><u>HMO 25</u></p> <p><u>EMERGENCY SERVICES</u></p> <p>In providing for emergency services and care as a covered service, a health maintenance organization may not:</p> <p>(a) Require prior authorization for the receipt of pre-hospital transport or treatment or for emergency services and care.</p> <p>(b) Indicate that emergencies are covered only if care is secured within a certain period of time.</p> <p>(c) Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.</p> <p>(d) Deny payment based on the subscriber's failure to notify the health maintenance organization in advance of seeking treatment or within a certain period of time after the care was given.</p> <p>s. 641.513(1), F.S.</p>	<p>Pre-hospital and hospital based trauma services and emergency services and care must be provided to a subscriber of a health maintenance organization as required under ss.395.1041, 395.4045, and 401.45, F.S.</p> <p>s. 641.513(2), F.S.</p> <p>A subscriber may be charged a reasonable copayment, as provided in s. 641.31(12), for the use of an emergency room.</p> <p>s. 641.513(4), F.S.</p> <p>Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:</p> <p>(a) The provider's charges;</p>	<p>Review policies and procedures regarding emergency services and the provision of these services for subscribers.</p> <p>Review the member handbook for a clear description of how to access emergency services and that the description does not use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered, require prior authorization for the receipt of pre-hospital transport or treatment or for emergency services and care, or indicate that emergencies are covered only if care is secured within a certain period of time.</p> <p>Review the member card for instructions for the subscriber of how to access emergency services and that these instructions correlate with policies and</p>

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	<p>(b) The usual and customary provider charges for similar services in the community where the services were provided; or</p> <p>(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim. Such reimbursements shall be net of any applicable copayment authorized pursuant to subsection (4). s.641.513(5), F.S.</p> <p>Each health maintenance contract, certificate, or member handbook shall state that emergency services and care shall be provided to subscribers in emergency situations not permitting treatment through the health maintenance organization’s providers, without prior notification to and approval of the organization. s. 641.31(12), F.S.</p>	<p>procedures and instructions in the subscriber agreement and member handbook.</p> <p>Review the provider manual for policies and procedures regarding emergency services..</p>
<p><u>HMO 26</u></p> <p><u>QUALITY OF CARE</u></p> <p>Maintenance of a professional staff or arrangements with providers duly licensed as required to practice in Florida.</p> <p>59A-12.006(3)(g), F.A.C.</p>	<p>“Provider” means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state. s. 641.19(15), F.S. s. 641. 47(14),F.S.</p> <p>Physician means:</p> <ol style="list-style-type: none"> 1. Medical Doctors licensed under Chapter 458, F.S. 2. Osteopathic Physicians licensed under Chapter 459, F.S. 3. Chiropractors licensed under Chapter 460, F.S. 4. Podiatrists licensed under Chapter 461, F.S. 	<p>Review policy and procedures for documentation that a policy for establishing and maintaining a professional staff or arrangements with providers sufficient to meet subscriber needs has been adopted.</p> <p>Review 25 credentialing files for verification of current Florida licenses for the Plan’s professional staff.</p>

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<p><u>HMO 27</u></p> <p><u>QUALITY OF CARE</u></p> <p>Make grievance files available during normal business hours for inspection by the agency. The files shall contain a written summary of the action taken by the HMO or PHC, including actions taken through the review by the quality improvement process, with exception of protected peer review information.</p> <p>59A-12.006(4), F.A.C.</p>	<p>An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.</p> <p>s.641.511(1), F.S.</p> <p>Each organization shall send to the agency a copy of its quarterly grievance reports submitted to the Office of Insurance Regulation pursuant to s.408.7056(12).</p> <p>s. 641.511(7), F.S.</p>	<p>Review policy and procedures for documentation that a policy for filing, processing, and maintaining a summary of action taken for subscriber grievances has been adopted.</p> <p>Review subscriber handbook to verify that information regarding the grievance procedure is available to all subscribers.</p>
<p><u>HMO 28</u></p> <p><u>QUALITY OF CARE</u></p> <p>Coordinate the overall health care of each member, and when possible, provision of this coordination through a single health care professional, who will maintain a unified record on the member.</p> <p>59A-12.006(6), F.A.C.</p>	<p>If offering services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or chapter 459 and chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating health care of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network.</p> <p>s.641.19(13)(e), F.S.</p>	<p>Review policy and procedures for documentation that a policy regarding coordination of health care and maintenance of a unified health record has been established.</p>

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	<p>The professional judgment of a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 concerning the proper course of treatment of a subscriber shall not be subject to modification by the organization or its board of directors, officers, or administrators, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community. However, this subsection shall not be considered to restrict a utilization management program established by the organization. s.641.51(3), F.S.</p>	
<p><u>HMO 29</u> <u>QUALITY OF CARE</u> Assure that the services provided members through referral sources are reported to the HMO or PHC or a designated health care professional in order that all appropriate medical information is filed in the member's medical record in a timely manner. 59A-12.006(6), F.A.C.</p>		<p>Review medical records policy and procedures for documentation that a policy and clearly defined procedures for making a referral and obtaining and recording pertinent clinical information from the referral source has been established.</p>
<p><u>HMO 30</u> <u>QUALITY OF CARE</u> Provide a system whereby a member may request and obtain a second medical opinion if the member feels that he is not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the condition being treated. The primary care physician must be so informed by the member, and a request for a consultation initiated. Such a consultation shall be provided upon authorization by the Medical Director.</p>	<p>Second medical opinion. A consultation by a physician other than the member's primary care physician, whose specialty is appropriate to the need, and whose services are obtained when the member disputes the appropriateness or necessity of a surgical procedure, is subject to a serious injury or illness, including failure to respond to the current treatment plan. 59A-12.002(11), F.A.C.</p>	<p>Review policy and procedures for verification that a written policy and procedure has been established for obtaining a second medical opinion.</p>

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59A-12.006(7), F.A.C.		
<p><u>HMO 31</u></p> <p><u>QUALITY OF CARE</u></p> <p>Each organization shall give the subscriber the right to a second medical opinion in any instance in which the subscriber disputes the organization's or the physician's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness.</p> <p>s. 641.51(5)(a), F.S.</p>	<p>The second opinion, if requested, is to be provided by a physician chosen by the subscriber who may select:</p> <ol style="list-style-type: none"> 1. A contract or employed physician listed in a directory that shall be provided by the organization; or 2. A non-contract physician located in the same geographic service area of the organization. <p>s. 641.51(5)(b), F.S.</p> <p>For second opinions provided by contract physicians the organization is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The organization shall pay the amount of all charges which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with the organization, but may require the subscriber to be responsible for up to 40 percent of such amount. The organization may require that any tests deemed necessary by a non-contract physician shall be conducted by the organization. The organization may deny reimbursement rights granted under this section in the event the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the organization to be evidence that the subscriber has unreasonably over-utilized the second opinion privilege. A subscriber thus denied reimbursement under this section shall have recourse to grievance procedures as specified in ss. 408.7056, 641.495, and 641.511, F.S. The</p>	

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	<p>organization's physician's professional judgment concerning the treatment of a subscriber derived after review of a second medical opinion shall be controlling as to the treatment obligations of the health maintenance organization. Treatment not authorized by the health maintenance organization shall be at the subscriber's expense. s. 641.51(5)(c), F.S.</p>	
<p><u>HMO 32</u></p> <p><u>QUALITY ASSURANCE</u></p> <p>Each HMO or PHC shall have an ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care and resolve identified problems at the prevailing professional standard of care.</p> <p>59A-12.007(1), F.A.C.</p>	<p>Cross refer to HMO 2, 59A-12.004(1)(b), F.A.C., for standards adopted by the governing body which address the overall organization and structure of the quality assurance program.</p> <p>Each organization shall have an ongoing internal quality assurance program for its health care services. The program shall include, but not be limited to, the following:</p> <ul style="list-style-type: none"> (a) A written statement of goals and objectives which stress health outcomes as the principle criteria for the evaluation of the quality of care rendered to subscribers; (b) A written statement describing how state-of-the-art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers. <p>s. 641.51(2)(a)(b), F.S.</p>	<p>Review the Quality Improvement Program for goals, scope, objectives, and purpose of the quality assurance program.</p> <p>Review the policy and procedures for documentation that clearly defined procedures have been developed for monitoring and evaluating the quality and appropriateness of patient care and resolving identified problems.</p> <p>Review Quality Improvement committee minutes to identify that the adopted Quality Improvement Plan has been implemented.</p> <p>Verify that standards adopted by the governing body which address the overall organization and structure of the quality assurance program have been carried through in the Quality Improvement Program that has been implemented.</p> <p>If the organization has delegated a role in the utilization management/referral, credentialing, grievance, or quality assurance process to contracted</p>

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		<p>providers or entities, verify that the organization has a process in place for oversight activities to determine the quality of the services being provided and to systematically monitor and to evaluate the quality and appropriateness of care being provided to subscribers. Verify that there is a process in place for approval by the organization of the delegation.</p>
<p><u>HMO 33</u></p> <p><u>QUALITY ASSURANCE</u></p> <p>The quality assurance plan is in writing and shall describe the program’s objectives, organization, and problem solving activities.</p> <p>59A-12.007(2), F.A.C.</p>		<p>Review the Quality Improvement Plan for a description of the program’s objectives, organization, and problem solving activities.</p> <ol style="list-style-type: none"> 1) Line of authority. 2) Committee structure. 3) Line of accountability. 4) Criteria for internal monitoring and problem solving activities. 5) Standards. 6) Methods and time frames for implementing the plan. 7) Follow-up.
<p><u>HMO 34</u></p> <p><u>QUALITY ASSURANCE</u></p> <p>The Scope of the program shall include, at a minimum, the following:</p> <ol style="list-style-type: none"> a) Evaluation of clinical performance (peer review) b) Review of medication usage. c) Evaluation as to the appropriate use of tests and studies, for example: lab, x-ray, and EKG. d) Evaluation of subscriber grievances. e) Evaluation of outcomes of care using criteria developed by physicians and other health professionals to evaluate patient care patterns and 	<p>Areas to be addressed when determining “scope” include:</p> <ol style="list-style-type: none"> 1) Criteria for selecting areas of study. 2) Frequency and duration of studies. 3) Selection process for data sources. 4) Line of authority/accountability. <ol style="list-style-type: none"> a) Governing body. b) Medical Director. c) Executive Director. 5) Quality assurance committee selection criteria. 	<p>a) Evaluation of clinical performance(peer review): Review the policy and procedures for documentation that the scope of the program includes peer review.</p> <p>Review policy and procedures of the peer review process for documentation of trending, analysis, and recommendations for corrective action as indicated.</p> <p>b) Review of medication usage: Review quality assurance policy and procedures for</p>

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<p>clinical performance for health services provided; and</p> <p>f) Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been provided were not.</p> <p>59A-12.007(3), F.A.C.</p>	<p>6) Method of reporting/recording outcomes of care.</p> <p>7) Mechanism for follow-up.</p> <p>8) External review process.</p> <p>9) Trending, analysis, and recommendations for corrective action.</p> <p>The program shall include, but not be limited to, the following: A written plan for providing review of physicians and other licensed medical providers that includes ongoing review within the organization. s.641.51(2)(d), F.S.</p> <p>“Provider” means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state. s.641.47(14), F.S.</p> <p>“Peer Review”. Ongoing evaluation of services by Florida licensed health care professionals to achieve and maintain high standards of professional practice within the discipline. 59A-12.002(7), F.A.C.</p> <p>The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers in the community. 59A-12.002(8), F.A.C.</p>	<p>documentation that:</p> <ol style="list-style-type: none"> 1) The scope of the program includes review of medication usage. 2) Procedures for evaluating review of medication usage are clearly defined. <p>Review quality assurance policy and procedures of medication usage to verify sources of data provide sufficient information to ensure a comprehensive study.</p> <ol style="list-style-type: none"> 1) Medication error/variance reports. 2) Drug profiles. 3) Drug ordering and refill protocol. 4) Pharmacy services. Oversight activities through site visit audits if applicable. <ol style="list-style-type: none"> a) Labeling b) Dispensing c) Patient identification. d) Reporting procedures for errors/variiances. 5) Patient information/education methods regarding medication usage. <p>c) Evaluation as to appropriate use of tests and studies:</p> <p>Review quality assurance policy and procedures for documentation that:</p> <ol style="list-style-type: none"> 1) The scope of the program includes evaluation as to the appropriate use of tests and studies. 2) Procedures for evaluating appropriate use of tests and studies are clearly defined. <p>Review quality assurance policies and procedures to verify sources of data provide sufficient information to ensure a comprehensive study.</p> <p>Review quality assurance policies and procedures for studies of appropriate use of tests and studies for documentation of trending, analysis, and recommendations for corrective action as indicated.</p>

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		<p>d) Evaluation of subscriber grievances: Review policy and procedures for documentation that:</p> <ol style="list-style-type: none"> 1) A policy for evaluation of subscriber grievances has been established. 2) Procedures have been adopted for evaluation of subscriber grievances. <p>Review quality assurance studies for evaluation of subscriber grievances to verify sources of data provide sufficient information to ensure a comprehensive study.</p> <ol style="list-style-type: none"> 1) Formal subscriber grievances. <ol style="list-style-type: none"> a) Timely processing (not to exceed 60 days). b) Appropriate physician involvement if grievance is medically related. (Refer to grievance procedure.) c) Complete description of HMO's conclusions. d) Complete description of the grievance. e) A member of the organization who has authority to make a determination concerning subscriber grievances shall participate in each level of the grievance procedure. 2) Subscriber handbook, contracts, or similar document to verify that information on how to file a grievance is disseminated to all subscribers. 3) Informal subscriber grievances. <ol style="list-style-type: none"> a) Access to the grievance coordinator. b) Access to the organization's toll free number to present a grievance. c) Complete description of grievance. d) Complete description of the Plan's conclusions. e) Timely processing of grievance. <p>Review policies and procedures for documentation of trending, analysis, and recommendations for corrective action as indicated.</p>

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		<p>e) Evaluation of outcomes of care: Review policy and procedures for documentation that:</p> <ol style="list-style-type: none"> 1) A policy for evaluation of outcomes of care has been established. 2) Clearly defined procedures for evaluating outcomes of care have been established. <p>Review policies and procedures for evaluation of outcomes of care to verify sources of data provide sufficient information to ensure a comprehensive study.</p> <ol style="list-style-type: none"> 1) Patient clinical records randomly selected from specialties, primaries, and all geographic areas served. <ol style="list-style-type: none"> a) Reasonably expected outcomes of care that are consistent with diagnoses, clinical impressions, and medical interventions. b) Referrals or consultations as indicated, obtained in a timely manner. c) Appropriateness of treatment. d) Accuracy of diagnoses, findings, and assessments. e) Appropriate follow-up. f) Complete, accurate, and timely communication between specialties and primaries. 2) Credentialing documents. <ol style="list-style-type: none"> a) Consistency of level of expertise and training with current clinical practice. 3) Peer review studies of outcomes of care and clinical performance. <ol style="list-style-type: none"> a) Appropriateness and timeliness of diagnostic tests and studies. b) Appropriateness and timeliness of referrals and consultation. c) Medication usage. d) Appropriateness, timeliness, and outcome of surgical and diagnostic procedures.

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		<p>e) Adherence to prevailing standards of care.</p> <p>4) Subscriber grievances for allegations of dissatisfaction with outcomes of care.</p> <p>F) Written procedures for taking appropriate remedial action: Review policy and procedures for documentation that a policy and clearly defined procedures have been established for taking remedial action whenever inappropriate or substandard services have been provided or services which should have been provided were not. Areas to be included are:</p> <ol style="list-style-type: none"> 1) Chain of command. <ol style="list-style-type: none"> a) Medical Director. b) Administrator. c) Governing body. 2) Contract renewal. 3) Reporting to state regulatory agencies. 4) Restriction of scope of practice. 5) Disciplinary action. 6) Patient notification. 7) Fee adjustment.
<p><u>HMO 35</u></p> <p><u>QUALITY ASSURANCE</u></p> <p>All findings, conclusions, recommendations, actions taken and results of actions taken shall be documented and reported through organizational channels that have been established.</p> <p>59A-12.007(4), F.A.C.</p>	<p>Refer to 59A-12.004(1)(b), F.A.C., (HMO 2), for quality assurance accountability to the governing body.</p>	<p>Review policy and procedures for documentation that a written policy and clearly defined procedures have been adopted for reporting through organizational channels all findings, conclusions, recommendations, actions taken and results of actions taken for all geographic service areas.</p> <p>Review other sources for documentation that findings, conclusions, actions taken and results of actions taken are reported through organizational channels. For</p>

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		<p>example:</p> <ol style="list-style-type: none"> 1. Organizational chart for position of quality assurance in the chain of command structure in relation to: <ol style="list-style-type: none"> a) Medical director. b) HMO administrator. c) Governing body. 2. Quality assurance committee minutes. 3. Governing body minutes. 4. Peer review committee minutes.
<p><u>HMO 36</u></p> <p><u>ACCREDITATION</u></p> <p>As a condition of doing business in the state, each HMO or PHC shall apply for accreditation within 1 year and be accredited within 2 years of the organization's receipt of its Certificate of Authority. All HMOs and PHCs must undergo re-accreditation not less than once every 3 years. Accreditation and re-accreditation must be awarded by an accreditation organization approved by the Agency pursuant to 59A-12.0072, F.A.C.</p> <p>59A-12.0071, F.A.C.</p>	<p>The accreditation process shall include a review of:</p> <p>(b) At least a representative sample of not fewer than 50 medical records of individual subscribers. When selecting a sample, any and all medical records may be subject to review. The sample of medical records shall be representative of all subscribers' records.</p> <p>s. 641.512(4)(b), F.S.</p> <p>The accreditation or review organization shall issue a written report of its findings to the health maintenance organization's or prepaid health clinic's board of directors. A copy of the report shall be submitted to the department by the organization within 30 business days of its receipt by the health maintenance organization or prepaid health clinic.</p> <p>s. 641.512(6), F.S.</p>	<p>Verify that the accrediting organization being considered has been approved by the Agency for Health Care Administration.</p>

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<p><u>HMO 37</u></p> <p><u>REFERRAL PROCESS</u></p> <p>Each HMO or PHC must have in place: A system to facilitate referral of subscribers to contracted or non-contracted physician and hospital providers; and, in the case of non-contracted providers, include a procedure for prior authorization and written notification regarding such referral to the subscriber.</p> <p>59A-12.008(1), F.A.C.</p>	<p>Subscribers shall have access to the physicians licensed under Chapter 460 and Chapter 461, assigned pursuant to Rule 4-191.046(2), F.A.C., without the need for referrals from physicians licensed under Chapter 458 or Chapter 459, assigned pursuant to Rule 4-191.046(1), F.A.C. 4-191.046(3), F.A.C.</p> <p>A health maintenance organization that provides dermatological services shall provide direct patient access for office visits and minor procedures and testing, to a dermatologist who is under contract with the health maintenance organization..... The criteria may include a maximum of 5 office visits to a dermatologist without prior authorization for a dermatologic problem within a 12 - month period. s.641.31(33), F.S.</p> <p>If a contracted primary care physician, licensed under Chapter 458 or Chapter 459, determines that a subscriber requires examination by a licensed ophthalmologist for medically necessary, contractually covered services, then the organization shall authorize the contracted primary care physician to send the subscriber to a contracted licensed ophthalmologist. s.641.51(12), F.S.</p> <p>Standards of Practice. The Board of Medicine interprets the standard of care requirement of Section 458.331(1)(t), Florida Statutes, and the delegation of duties restrictions of Section 458.311(1)(w), Florida Statutes, with regard to surgery as follows: Management of postsurgical care is the responsibility of the operating surgeon. 64B8-9.007(2), F.A.C.</p>	<p>Review policy and procedure manual for documentation that a written policy and procedure has been established for referral to contracted and non-contracted physician and hospital providers.</p> <p>Review a selected sample of patient records for verification that prior authorization was obtained and the subscriber was notified in writing regarding the referral to non-contracted providers.</p> <p>Review the member handbook and subscriber agreement for documentation that a policy and procedure has been established for referral to contracted and non-contracted physician and hospital providers.</p> <p>Verify that lists of all contract physicians and hospitals available to subscribers are complete, accurate, and current for each geographic service area.</p> <p>Review subscriber complaints and grievances for allegations of dissatisfaction with the referral procedure.</p> <p>Review the provider manual and contracts for documentation that a policy and procedure has been established for referral to contracted and non-contracted physician and hospital providers.</p> <p>If the organization has delegated utilization management and/or the referral process to a contracted provider or entity, verify that the policies and procedures of the delegated provider or entity are consistent with the policies and procedures of the organization and there is evidence of oversight activities of the organization to determine that required standards are maintained. Verify that there is a process in place for approval by the organization of the delegation</p>

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	<p>The organization shall ensure that only a physician holding an active unencumbered license issued under chapter 458 or chapter 459, may render an adverse determination regarding a service provided by a physician licensed in this state. The organization shall submit to the treating provider and the subscriber written notification regarding the organization’s adverse determination 2 working days after the subscriber or provider is notified of the adverse determination. The written notification must include the utilization review criteria or benefits provisions used in the adverse determination, identify the physician who rendered the adverse determination, and be signed by an authorized representative of the organization or the physician who rendered the adverse determination. The organization must include with the notification of an adverse determination information concerning the appeal process for adverse determinations. s. 641.51(4), F.S.</p> <p>The health maintenance organization must establish written procedures for a contract provider to request and the health maintenance organization to grant authorization for utilization of health care services. The health maintenance organization must give written notice to the contract provider prior to any change in these procedures. s.641.315(8), F.S.[Effective date: 10/01/2000]</p>	
<p><u>HMO 38</u></p> <p><u>REFERRAL PROCESS</u></p> <p>The health maintenance organization must provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending unless the requesting provider contractually agrees to take a pending or tracking number.</p>	<p>s.641.495(4), F.S. - Effective date: 10/01/2000.</p> <p>A claim for treatment may not be denied if a provider follows the health maintenance organization’s authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the health maintenance organization</p>	<p>Review policies and procedures of the organization to provide for treatment authorization 24 hours a day, 7 days a week and that requests for treatment authorization are not held pending unless the requesting provider contractually agrees to take a pending number.</p> <p>Review authorization logs/tracking systems to establish that a process for treatment authorization is</p>

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<p>s.641.495(4), F.S.</p>	<p>with the willful intention to misinform the health maintenance organization. s.641.3156(2), F.S. [Effective: 10/01/2000]</p>	<p>available 24 hours a day, 7 days a week and that requests for treatment authorization are not held pending unless the requesting provider contractually agrees to take a pending number.</p> <p>Review the provider manual for a description of the authorization process to include that treatment authorization is available 24 hours a day, 7 days a week.</p> <p>Review tracking and trending of complaints and grievances, complaint and grievance logs, and grievance files for allegations of difficulties in obtaining authorizations.</p> <p>If the organization has delegated utilization management and/or the authorization/referral process to a contracted provider or entity, verify that the policies and procedures of the delegated provider or entity are consistent with the policies and procedures of the organization and there is evidence of oversight activities of the organization to determine that required standards are maintained. Verify that there is a process in place for approval by the organization of the delegation.</p>
<p><u>HMO 39</u></p> <p><u>REFERRAL PROCESS</u></p> <p>Each organization shall develop and maintain a policy to determine when exceptional referrals to out-of-network specially qualified providers should be provided to address the unique medical needs of a subscriber. All financial arrangements for the provision of these services shall be agreed to prior to the services being rendered.</p> <p>s.641.51(6), F.S.</p>		<p>Review policy and procedures for documentation that a written policy and procedure has been established for exceptional referrals to out of network providers.</p> <p>Review the member handbook for documentation of a procedure to request exceptional referrals to out of network providers.</p> <p>Review the provider manual for documentation of a</p>

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		policy and procedure for exceptional referrals to out of network providers.
<p><u>HMO 40</u></p> <p><u>REFERRAL PROCESS</u></p> <p>A means for notifying the subscriber of the referral system, including the procedures for the subscribers to obtain a second medical opinion. Such notification is clearly stated in either the subscriber contract, member handbook, or other written communication.</p> <p>59A-12.008(2), F.A.C.</p>		<p>Review the member handbook, or similar form of document for verification that the referral system, including the procedure for the subscribers to obtain a second medical opinion, is clearly stated and made available to each subscriber.</p>
<p><u>HMO 41</u></p> <p><u>REFERRAL PROCESS</u></p> <p>Each organization shall develop and maintain written policies and procedures for the provision of standing referrals to subscribers with chronic and disabling conditions, which require ongoing specialty care.</p> <p>s.641.51(7), F.S.</p>		<p>Review policy and procedures for documentation that a written policy and procedure has been established for standing referrals to subscribers with chronic and disabling conditions that require ongoing specialty care.</p> <p>Review the member handbook for documentation of a procedure for standing referrals to subscribers with chronic and disabling conditions that require ongoing specialty care.</p> <p>Review the provider manual for documentation of a policy and procedure for standing referrals to subscribers with chronic and disabling conditions that require ongoing specialty care.</p>
<p><u>HMO 42</u></p>		

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<p><u>REFERRAL PROCESS</u></p> <p>When a contract between an organization and a treating provider is terminated for any reason other than for cause, each party shall allow subscribers for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the subscriber was receiving care at the time of termination, until the subscriber selects another treating provider, or during the next open enrollment period offered by the organization, whichever is longer, but not longer than 6 months after termination of the contract. Each party to the terminated contract shall allow a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until the completion of postpartum care. s.641.51(8),F.S.</p>		<p>Review the policy and procedures for documentation that a written policy and procedure has been established for allowing subscribers to continue coverage and care with a terminated treating provider when medically necessary, and according to statutory requirements or, in the case of a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until the completion of postpartum care.</p> <p>Review the provider manual for documentation of a policy and procedure for allowing subscribers to continue coverage and care with a terminated treating provider when medically necessary, and according to statutory requirements or, in the case of a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until the completion of postpartum care.</p>
<p><u>HMO 43</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>Every organization certified under this part shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:</p> <p>The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients.</p>	<p>Risk management means the identification, investigation, analysis, and evaluation of risks and the selection of the most advantageous method of correcting, reducing, or eliminating identifiable risks.</p> <p>The organization may call incident reports by other names, such as variance reports, or occurrence reports.</p>	<p>The 1996 Legislative session amended the 1995 version of s. 641.49(p) and s.641.55 F.S., to include that PHCs must also comply with internal risk management program requirements</p> <p>Review risk management policy and procedures for documentation that a policy and procedure for investigation and analysis of the frequency and causes of general categories and specific types of incidents</p>

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s. 641.55(1)(a), F.S.		<p>has been established.</p> <p>Review risk manager’s job description for reference to risk management role in incident investigation and analysis.</p> <p>Review monthly or quarterly summary reports for documentation of incident investigation and analysis.</p> <p>Review risk management, safety, and/or quality assurance committee reports or minutes for documentation of incident investigation and analysis.</p>
<p><u>HMO 44</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>The development of appropriate measures to minimize the risk of injuries and adverse incidents.</p> <p>s.641.55(1)(b), F.S.</p>	<p>Risk management policy and procedure manual, job description, and committee minutes may refer to measures to minimize the risk of injuries and incidents to patients as loss prevention, loss control, or risk reduction.</p>	<p>Review risk management policy and procedures for documentation that a program for minimization of risk injuries and incidents to patients has been established.</p> <p>Review risk manager’s job description for reference to risk manager’s role in reducing risk of injuries and incidents to patients.</p>
<p><u>HMO 45</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>The analysis of patient grievances which relate to patient care and quality of medical services.</p> <p>s.641.55(1)(c), F.S.</p>	<p>“Complaint” means any expression of dissatisfaction by a subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization’s contract and which is submitted to the organization or to a state agency.</p>	<p>Review risk management policy and procedures for documentation that a policy and procedure for analyzing patient grievances related to quality of care has been established.</p> <p>Review risk manager’s job description for reference to risk manager’s role in analysis of patient grievances.</p>

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	<p>A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it a grievance as defined in subsection (10). s. 641.47(5), F.A.C.</p> <p>“Grievance” means a written complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:</p> <ul style="list-style-type: none"> (a) Availability, coverage, for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (b) Claims payment, handling, or reimbursement for health care services; or (c) Matters pertaining to the contractual relationship between a subscriber and an organization. <p>s. 641.47(10), F.S.</p>	
<p><u>HMO 46</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>The development and implementation of an incident reporting system based upon the affirmative duty of all providers and all agents and employees of the organization to report injuries and adverse incidents to the risk manager. s.641.55(1)(d), F.S.</p>	<p>The organization may call incident reports by other names, such as variance reports, or occurrence reports.</p>	<p>Review the risk management policy and procedures for documentation that an incident reporting system has been established.</p> <p>Review risk manager’s job description for reference to reporting of incidents.</p> <p>Review the organization’s orientation and annual update material and the provider manual’s content to determine if providers, agents, and employees have been made aware of the incident reporting system and their responsibility for reporting patient injuries and incidents to the risk manager.</p>
<p><u>HMO 47</u></p>		

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<p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>The risk management program shall be the responsibility of the governing body or board of the organization.</p> <p>s.641.55(2), F.S.</p>		<p>Review risk management policy and procedures for:</p> <ol style="list-style-type: none"> 1. Documentation that a policy has been established outlining the relationship between the risk management program and the governing body. 2. Documentation that procedures have been developed for reporting to and receiving information from the governing body regarding risk management. 3. Verification that the governing body assumes ultimate responsibility for the risk management program. <ol style="list-style-type: none"> a) Statement of authority signed by a representative of the governing body. b) Line of authority between risk management and the governing body. c) Review bylaws for documentation that the governing body has assumed the responsibility of the risk management program.
<p><u>HMO 48</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>Every staff model and combination of individual practice association and staff model HMO which has an annual premium volume of \$10 million or more shall employ or contract with a licensed risk manager who shall be responsible for implementation and oversight of the organization's internal risk management program.</p> <p>A part-time risk manager shall not be responsible for risk management programs in more than four organizations or facilities.</p>	<p>Every organization which has an annual premium volume of \$10 million or more and which directly provides health care in a building owned or leased by the organization shall hire a risk manager, certified under ss.395.10971-ss.395.10975, who shall be responsible for implementation of the organization's risk management program required by this section. A part-time risk manager shall not be responsible for risk management programs in more than four organizations or facilities. Every organization which does not directly provide health</p>	<p>A copy of the risk manager's license issued by the Department of Insurance, which shows license number and expiration date, will be made available to the surveyor, if applicable.</p> <p>Review risk management policy and procedures, and/or governing body minutes, for documentation that the designation of a risk manager is in writing, signed by a representative of the governing body.</p> <p>Question the organization's risk manager to verify that</p>

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<p>Every individual practice association model and every HMO with an annual premium volume of less than \$10 million shall designate an officer or employee of the HMO to serve as risk manager.</p> <p>59A-12.012(2), F.A.C.</p>	<p>care in a building owned or leased by the organization and every organization with an annual premium volume of less than \$10 million shall designate an officer or employee of the organization to serve as the risk manager.</p> <p>s.641.55(2), F.S.</p> <p>Designation of an officer or employee of the organization to serve as risk manager must be authorized in writing by the governing body.</p>	<p>he/she is not responsible for risk management programs in more than four organizations or facilities.</p>
<p><u>HMO 49</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>An incident reporting system shall be established for each HMO. Procedures shall be detailed in writing and disseminated to all employees of the HMO.</p> <p>59A-12.012(3), F.A.C.</p>	<p>Written incident reporting procedures must be disseminated to all employees, agents, and providers. These procedures include the definition of adverse or untoward incidents, the proper reporting form and instructions about completing the form, and the required time frame for reporting incidents to the risk manager.</p>	<p>Review the risk management policy and procedures for documentation that written procedures for incident reporting have been established.</p> <p>Verify the availability of written procedures for incident reporting to all employees, agents, and providers of the organization.</p> <ol style="list-style-type: none"> 1. Risk Management policies and procedures are located in areas accessible to employees and providers. 2. Handouts given to all employees and providers.
<p><u>HMO 50</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>All new employees, within 30 days of employment, shall be instructed in the operation and responsibilities of the incident reporting system.</p> <p>59A-12.012(3), F.A.C.</p>	<p>Every organization certified under this part shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:</p> <p style="padding-left: 40px;">Such education and training of all non-physician personnel as part of their initial orientation.</p> <p>s.641.55(1)(b)(1), F.S.</p>	<p>Review content of risk management orientation program for documentation that the operation of the incident reporting system is included.</p> <p>Review organization’s method of documenting attendance at risk management orientation. For example:</p> <ol style="list-style-type: none"> 1. Sign-in sheets.

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	<p>If a list of new employees is presented to document attendance at risk management orientation, the list must be of employees who actually attended and not scheduled to attend, along with the date of attendance.</p> <p>Employees who have been rehired within one year may be exempt if they received risk management orientation properly at first hire.</p> <p>This requirement includes all new employees directly employed by the organization in all departments.</p> <p>This requirement does not include individuals who have contracted with the HMO to provide specific services.</p>	<ol style="list-style-type: none"> 2. Computer printouts. 3. Copies of certificates of attendance. 4. Orientation checklists. <p>Select a random sample of names of a minimum of twelve staff members who were hired within the last 12 months for verification of instruction about the operation of the incident reporting system. Compare documented date of orientation with date of employment for verification that orientation was received within 30 days of employment.</p>
<p><u>HMO 51</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>At least annually all non-physician personnel employed by the organization working in clinical areas and providing patient care receive 1 hour of risk management and risk prevention education and training including the importance of accurate and timely incident reporting.</p> <p>59A-12.012(3), F.A.C.</p>	<p>Every organization certified under this part shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components</p> <p style="padding-left: 40px;">At least 1 hour of such education and training annually for all non-physician personnel of the organization who work in clinical areas and provide patient care.</p> <p>s. 641.55(1)(b)(2), F.S.</p> <p>This requirement does not include individuals who have contracted with the HMO to provide specific services.</p>	<p>Review content of the risk management annual update program for documentation that incident reporting is included.</p> <p>Review a random sample of a minimum of twelve clinical employee's in-service education files to verify that risk management and risk prevention training including the incident reporting system is included. Methods of verification include:</p> <ol style="list-style-type: none"> 1. Computer printout. 2. Copies of certificates of attendance. 3. Sign-in sheets. 4. In-service checklists.
<p><u>HMO 52</u></p>		

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<p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>The incident reporting system shall include the prompt, within three calendar days, reporting of incidents to the risk manager.</p> <p>59A-12.012(3), F.A.C.</p>	<p>Incidents may be reported to the risk manager or risk manager designee.</p> <p>Appointment of the risk manager designee must be in writing.</p> <p>“Designee” must be specifically noted and does not include personnel who are part of the routine “flow” for incident reporting unless that person is clearly noted in writing as the risk manager designee.</p> <p>A specific person or a position title may be appointed in writing as risk manager designee (Medical Director, Unit manager, etc.).</p> <p>Documentation of receipt of incident reports varies among organizations as to the use of date stamp, log, etc.</p>	<p>Review risk management policy and procedures for:</p> <ol style="list-style-type: none"> 1) Documentation that a policy and procedure for reporting incidents within the required time frame has been established. 2) A policy has been established requiring that the appointment of a risk manager designee be in writing. <p>Review risk manager’s job description for reference to timely receipt of incidents.</p> <p>Review risk manager designee’s job description for documentation that the duties and responsibilities of the risk manager designee are included.</p>
<p><u>HMO 53</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>Incident reports shall be on a form developed by the HMO for the purpose and shall contain at least the following information:</p> <ol style="list-style-type: none"> (a) The patient’s name, date of birth, sex, physical findings or diagnosis and, if hospitalized; locating information, admission time and date, and the facility’s name; (b) A clear and concise description of the incident including the time, date, exact location, coding elements as needed for the annual report based on ICD-9-CM; (c) Whether or not a physician was called and, if so, a brief statement of said physician’s recommendations 	<p>Incident report format will vary among organizations.</p> <p>The organization may call incident reports by other names, such as variance reports, or occurrence reports.</p> <p>Some organizations record medication errors on a different form. These forms should be approved and are considered to be part of the incident reporting system.</p>	<p>Review the incident report form for verification that the required information is included.</p>

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<p>as to the medical treatment, if any;</p> <p>(d) A listing of all persons known to be involved directly in the incident, including witnesses, along with locating information for each; and</p> <p>(e) The name, signature and position of the person completing the report, along with the date and time that the report was completed.</p> <p>59A-12.012(3), F.A.C.</p>		
<p><u>HMO 54</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>The HMO shall be responsible for regular and systematic review of all incident reports and written patient grievances for the purpose of identifying trends or patterns as to time, place or persons and upon emergence of any trend or pattern in incident occurrence, shall develop recommendations for appropriate corrective action and risk management prevention education and training. Summary data shall be maintained for 3 years.</p> <p>59A-12.012(4), F.A.C.</p>	<p>Summary reports may be monthly or quarterly.</p> <p>The risk manager may be a member of the safety, quality assurance and/or the risk management committees, therefore, evidence of trending, analysis, and recommendations may be found in these committee minutes.</p> <p>Recommendations are identified and verified.</p> <p>As a part of each internal risk management program, the incident reports shall be utilized to develop categories of incidents which identify problem areas. Once identified, procedures must be adjusted to correct these problem areas.</p> <p>s. 641.55(4), F.S.</p>	<p>Review risk management policy and procedures for documentation that a policy and procedure for the review of incident reports to identify trends or patterns has been established.</p> <p>Review risk manager’s job description for reference to risk manager’s role in incident analysis.</p>
<p><u>HMO 55</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>If an adverse or untoward incident, whether occurring in the facilities of the organization or arising from health care prior to enrollment by the organization or admission to the facilities of the organization or in the facility of one of its providers, results in:</p>		<p>Review risk management policy and procedures and job descriptions for verification that special category incident reporting policies and procedures, and required time frames for reporting are included.</p>

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<p>(a) The death of a patient; (b) Severe brain or spinal damage to a patient; (c) A surgical procedure being performed on the wrong patient; or (d) A surgical procedure unrelated to the patient’s diagnosis or medical needs being performed on any patient,</p> <p>The organization must report this incident to the agency within 3 working days after its occurrence. A more detailed follow-up report must be submitted to the agency within 10 days after the first report. The agency may require an additional, final report.</p> <p>s.641.55(6), F.S.</p>		
<p><u>HMO 56</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>The report is made on AHCA Form 3140-5001, “Code 15”, which is incorporated by reference. Any reportable incidents, pursuant to this section that are submitted more than 15 calendar days from occurrence by the organization must be justified in writing by the organization administrator.</p> <p>59A-12.012(5)(d), F.A.C.</p>		
<p><u>HMO 57</u></p> <p><u>INTERNAL RISK MANAGEMENT PROGRAM</u></p> <p>At least quarterly or more often as may be required by the governing body, the risk manager shall provide a summary report to the governing body which includes information about activities of risk management.</p> <p>59A-12.012(6), F.A.C.</p>	<p>Risk management means the identification, investigation, analysis, and evaluation of risks and the selection of the most advantageous method of correcting, reducing, or eliminating identifiable risks.</p>	<p>Review risk management policy and procedures and job description for the risk manager’s role in providing a summary report to the governing body at least quarterly.</p>

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	<p>The report to the governing body may be part of a packet of information that goes to each member for review prior to the general meeting.</p> <p>The risk management summary report may be documented in the governing body minutes separately or in conjunction with the Quality Assurance report, but the Quality Assurance report does not replace the risk manager’s report.</p>	
<p><u>HMO 58</u></p> <p><u>CREDENTIALING</u></p> <p>The organization shall have a system for verification and examination of the credentials of each of its providers.</p> <p>s.641.495(6), F.S.</p>	<p>“Provider” means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.</p> <p>s. 641.19(15), F.S.</p> <p>s. 641.47(14), F.S.</p>	<p>Review policy and procedures for documentation that policies and procedures for verification and examination of all providers’ credentials have been established.</p> <p>Verify that in addition to having a process in place for the verification of credentials of physicians, that there is an appropriate process in place for the verification of the credentials of each of its providers.</p> <p>Review medical staff bylaws, credentialing committee minutes, and/or quality improvement committee minutes, for reference to a system for examination and verification of credentials.</p> <p>Review list of items required for initial appointment and for renewal of contracts.</p> <p>If the organization has delegated the credentialing process to a contracted provider or entity, verify that the policies and procedures of the delegated provider or entity are consistent with the policies and procedures of the organization and there is evidence of oversight activities of the organization to determine that required standards are met and maintained. Verify that there is a process in place for approval by the</p>

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<p><u>HMO 59</u></p> <p><u>CREDENTIALING</u></p> <p>The organization shall maintain in a central file the credentials, including a copy of the current Florida license, of each of its physicians.</p> <p>s.641.495(6), F.S.</p>	<p>Maintenance in a central file of a copy of the screen from the Department of Health website (www.doh.state.fl.us –Licensure, Health Professional Look Up), which verifies current licensure, may currently be used in place of a copy of the current Florida license. It is the responsibility of the HMO/PHC to establish and maintain credentialing policies and procedures and an ongoing credentialing program and to be in compliance with state, federal, and accreditation organization requirements.</p>	<p>organization of the delegation.</p> <p>Review a random sample of a minimum of 25 primary and specialty files for verification that each file contains the required documents.</p> <p>Select a random sample of a minimum of twelve primary and specialty physicians’ names from the current list of physicians used by the organization pursuant to s. 59A-12.011, F.A.C., to verify that all physicians listed have a file containing the required information.</p> <p>If the organization has delegated the credentialing process to a contracted provider or entity, verify that the policies and procedures of the delegated provider or entity are consistent with the policies and procedures of the organization and there is evidence of oversight activities of the organization to determine that required standards are met and maintained. Verify that there is a process in place for approval of the delegation by the organization.</p>
<p><u>HMO 60</u></p> <p><u>CREDENTIALING</u></p> <p>The organization shall designate a medical director who is a physician licensed under chapter 458 or 459.</p> <p>s.641.495(11), F.S.</p>		<p>Review the credential file (s) of the medical director(s) to verify licensure under chapter 458 or 459.</p> <p>Review the organizational chart for identification of the designated medical director(s).</p>

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<p><u>HMO 61</u></p> <p><u>CREDENTIALING</u></p> <p>Each organization’s contracts, certificates and subscriber handbooks shall contain a provision, if applicable, disclosing that, for certain types of described medical procedures, services may be provided by physician assistants, nurse practitioners, or other individuals who are not licensed physicians.</p> <p>s.641.495(8), F.S.</p>	<p>A health maintenance organization shall not discriminate with respect to participation as to any advanced registered nurse practitioner licensed and certified pursuant to s. 464.012, who is acting within the scope of such license and certification, solely on the basis of such licensure or certification.</p> <p>s.641.3923,F.S.</p>	<p>Review contracts, certificates, and subscriber handbooks for verification that these documents disclose that certain types of services may be provided by non-physician personnel.</p> <p>Review list of procedures and services provided by PAs, ARNPs, and other individuals who are not licensed physicians.</p> <p>Review mechanism for evaluating performance of individuals other than licensed physicians.</p>
<p><u>HMO 62</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>Every organization shall have a subscriber grievance procedure, including, as appropriate, a procedure for disenrolling for cause, which is outlined in all master group and individual contracts as well as in any certificate or handbook provided to subscribers.</p> <p>s.641.495(9), F.S.</p>		<p>Review policy and procedures for documentation that a subscriber grievance procedure has been established.</p> <p>Review master group contracts and certificates or handbooks provided to the members that it has included an outline of the grievance procedure and verify that the outline is consistent with internal grievance policies and procedures of the organization.</p> <p>Review the provider manual for inclusion of the grievance procedure.</p> <p>If the organization has delegated a role in the grievance procedure to a contracted provider or entity, verify that the policies and procedures of the delegated</p>

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		provider or entity are consistent with the policies and procedures of the organization.
<p><u>HMO 63</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance, and may submit the grievance for review to the Subscriber Assistance Program as provided in s.408.7056 after receiving a final disposition of the grievance through the organization’s grievance process.</p> <p>s.641.511(1), F.S.</p>	<p>“Complaint” means any expression of dissatisfaction by a subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization’s contract and which is submitted to the organization or to a state agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it a grievance as defined in subsection (10).</p> <p>s. 641.47(5), F.S.</p> <p>“Grievance” means a written complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:</p> <ul style="list-style-type: none"> (d) Availability, coverage, for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (e) Claims payment, handling, or reimbursement for health care services; or (f) Matters pertaining to the contractual relationship between a subscriber and an organization. <p>s. 641.47(10), F.S.</p>	<p>Review the grievance policy and procedures for provisions to notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance, and for submitting the grievance for review to the Subscriber Assistance Program as provided in s.408.7056 after receiving a final disposition of the grievance through the organization’s grievance process.</p> <p>Review grievance form letters for inclusion of information notifying subscribers that they may submit the grievance for review to the Subscriber Assistance Program after receiving a final disposition of the grievance through the organization’s grievance process.</p>
<p><u>HMO 64</u></p> <p><u>GRIEVANCE PROCESS</u></p>		

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<p>When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.</p> <p>s.641.511(2), F.S.</p>		<p>Review the grievance policy and procedures for a process for responding to an initial complaint in a timely manner.</p> <p>Review the grievance policy and procedures for a process for informing the subscriber at the time of the initial complaint of their right to file a written grievance and that if assistance in preparing the written grievance is needed, it shall be provided by the organization.</p>
<p><u>HMO 65</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>Each organization’s grievance procedure, as required under subsection (1) must include, at a minimum:</p> <ul style="list-style-type: none"> (a) an explanation of how to pursue redress of a grievance. (b) The names of the appropriate employees or a list of grievance departments that are responsible for implementing the organization’s grievance procedure. (c) The description of the process through which a subscriber may, at any time, contact the toll-free telephone hotline of the agency to inform it of the unresolved grievance. (d) A procedure for establishing methods for classifying grievances as urgent and for establishing time frames for an expedited review within which such grievances must be resolved. (e) A notice that a subscriber may voluntarily pursue binding arbitration in accordance with the terms of the contract if offered by the organization, after completing the organization’s grievance procedure and as an alternative to the Subscriber Assistance Program. (f) A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of the final 	<p>Each organization, as a part of its contract with any provider, must require the provider to post a consumer assistance notice prominently displayed in the reception area of the provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration, the Subscriber Assistance Program, and the Office of Insurance Regulation. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization’s grievance department shall be provided upon request.</p> <p>s. 641.511(11), F.S.</p> <p>The list must include the address and toll-free telephone number of each grievance department, the address of the agency and its toll-free telephone hotline number, and the address of the Subscriber Assistance Program and its toll free telephone number.</p> <p>s. 641.511(3)(b), F.S.</p>	<p>Review the grievance policy and procedures to verify the inclusion of the minimum requirements.</p> <p>Review the member handbook for documentation of the minimum requirements of the grievance procedure, including the address of the agency and its toll-free telephone hotline number, and the address of the Subscriber Assistance Program and its toll free telephone number.</p> <p>Review grievance form letters for inclusion of information notifying subscribers of how to pursue redress of a grievance.</p>

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<p>decision in writing. (g) A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process, which shall include assistance by the organization in preparing the grievance and communicating back to the subscriber.</p> <p>s.641.511(3), F.S.</p>	<p>“Urgent grievance” means an adverse determination when the standard timeframe of the grievance procedure would seriously jeopardize the life or health of a subscriber or would jeopardize the subscriber’s ability to regain maximum function.</p> <p>s. 641.47(17), F.S.</p> <p>Such notice shall include an explanation that the subscriber may incur some costs if the subscriber pursues binding arbitration, depending upon the terms of the subscriber’s contract.</p> <p>s. 641.511(3)(e), F.S.</p>	
<p><u>HMO 66</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>With respect to a grievance concerning an adverse determination, an organization shall make available to the subscriber a review of the grievance by an internal review panel; such review must be requested within 30 days after the organization’s transmittal of the final determination notice of an adverse determination.</p> <p>s.641.511(4)(a), F.S.</p>	<p>“Adverse determination” means a coverage determination by an organization that an admission, availability of care, continued stay, or other health care service has been reviewed and , based upon the information provided, does not meet the organization’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.</p> <p>s. 641.47(1), F.S.</p> <p>A majority of the panel shall be persons who previously were not involved in the initial determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to</p>	<p>Review the grievance policy and procedures to verify the inclusion of a process for review of an adverse determination.</p> <p>Review the member handbook for documentation of a process for review of an adverse determination.</p>

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	bind the organization to the panel's decision. s. 641.511(4)(a), F.S.	
<p><u>HMO 67</u></p> <p><u>GRIEVANCE PROCEDURE</u></p> <p>An organization shall insure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber.</p> <p>s.641.511(4)(b), F.S.</p>	<p>In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved in the adverse determination.</p> <p>s. 641.511(4)(b), F.S.</p>	<p>Review the grievance policy and procedures to verify the existence of a provision to insure that the majority of the providers reviewing a grievance involving an adverse determination have appropriate expertise.</p> <p>Review the grievance policy and procedures to verify the existence of a process for issuing a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submitted the grievance on behalf of a subscriber.</p>
<p><u>HMO 68</u></p> <p><u>GRIEVANCE PROCEDURE</u></p> <p>An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.</p> <p>s. 641.511(4)(c), F.S.</p>	<p>To submit or pursue a grievance on behalf of a subscriber, a provider must previously have been directly involved in the treatment or diagnosis of the subscriber.</p> <p>s. 641.47(14), F.S.</p> <p>The organization shall ensure that only a physician licensed under chapter 458 or chapter 459, or an allopathic or osteopathic physician with an active, unencumbered license in another state with similar licensing requirements may render an adverse determination regarding a service provided by a physician licensed in this state. The organization shall submit to the treating provider and the subscriber written notification regarding the organization's adverse determination 2 working days after the subscriber or provider is notified of the adverse determination. The written notification must include the utilization review criteria or</p>	<p>Review the grievance policy and procedures to verify the existence of written policies and procedures for a review of an adverse determination.</p> <p>Review the grievance policy and procedures to verify that review procedures shall be available to the subscriber and to provider acting on behalf of a subscriber.</p> <p>Review the member handbooks to verify the existence of written procedures for a review of an adverse determination.</p> <p>Review the provider manual to verify the existence of written policies and procedures for a review of an adverse determination.</p>

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	<p>benefits provisions used in the adverse determination, identify the physician who rendered the adverse determination, and be signed by an authorized representative of the organization or the physician who rendered the adverse determination. The organization must include with the notification of an adverse determination information concerning the appeal process for adverse determinations. s. 641.51(4), F.S.</p>	
<p><u>HMO 69</u></p> <p><u>GRIEVANCE PROCEDURE</u></p> <p>In any case when the review process does not resolve a difference of opinion between the organization and the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.</p> <p>s.641.511(4)(d), F.S.</p>		<p>Review the policy and procedures for a review of an adverse determination to verify the inclusion of provisions for the subscriber or the provider acting on behalf of the subscriber to submit a written grievance to the Subscriber Assistance Program.</p>
<p><u>HMO 70</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area.</p> <p>The Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. 2560.503-1, is adopted and incorporated by reference as applicable to all organizations that administer small and large group health plans that are subject to 29 C.F.R. 2560.503-1. The claims procedures for the regulations of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. 2560.503-1 shall be the minimum standards for grievance</p>	<p>These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitation are tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes.</p> <p>s. 641.511(5), F.S.</p>	<p>Review the grievance policy and procedures for provisions for the resolution of a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area.</p> <p>Review the member handbook for provisions for the resolution of a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area.</p>

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<p>processes for claims for benefits for small and large group health plans that are subject to 29 C.F.R. 2560.503-1.</p> <p>641.511(5), F.S.</p>		
<p><u>HMO 71</u> <u>GRIEVANCE PROCESS</u></p> <p>An organization shall establish written procedures for the expedited review of an urgent grievance. A request for an expedited review may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section.</p> <p>s.641.511(6)(a). F.S.</p>	<p>Unless it is submitted in writing, for purposes of the grievance reporting requirements in subsection (1), the request shall be considered an appeal of a utilization review decision and not a grievance. Expedited review procedures shall be available to a subscriber and to the provider acting on behalf of a subscriber. For purposes of this subsection, “subscriber” includes the legal representative of a subscriber.</p> <p>s. 641.511(6)(a), F.S.</p> <p>“Urgent grievance” means an adverse determination when the standard timeframe of the grievance procedure would seriously jeopardize the life or health of a subscriber or would jeopardize the subscriber’s ability to regain maximum function.</p> <p>s. 641.47(17),F.S.</p> <p>An organization shall not provide an expedited retrospective review of an adverse determination.</p> <p>s. 641.511(6)(h), F.S.</p> <p>“Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols, and abstract guidelines used by the organization to determine for coverage purposes, the necessity and appropriateness of health care services,</p> <p>s. 641.47(4), F.S.</p>	<p>Review the grievance policy and procedures for written procedures for the expedited review of an urgent grievance.</p> <p>Review the member handbook for evidence of a written procedure for the expedited review of an urgent grievance.</p> <p>Review the provider manual for evidence of a written procedure for the expedited review of an urgent grievance.</p>

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<p><u>HMO 72</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>Expedited reviews shall be evaluated by an appropriate clinical peer or peers. The clinical peer or peers shall not have been involved in the initial adverse determination.</p> <p>s.641.511(6)(b), F.S.</p>	<p>“Clinical peer” means a health care professional in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.</p> <p>s. 641.47(3), F.S.</p> <p>An organization shall provide reasonable access, not to exceed 24 hours after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.</p> <p>s. 641.511(6)(f), F.S.</p>	<p>Review the grievance policy and procedures for a process for expedited reviews to be evaluated by an appropriate clinical peer or peers.</p>
<p><u>HMO 73</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>In an expedited review, an organization shall make a decision and notify the subscriber, or the provider acting on behalf of the subscriber, as expeditiously as the subscriber’s medical condition requires, but in no event more than 72 hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the subscriber until the subscriber has been notified of the determination.</p> <p>s.641.511(6)(d), F.S.</p>	<p>In an expedited review, all necessary information, including the organization’s decision, shall be transmitted between the organization and the subscriber, or the provider acting on behalf of the subscriber, by telephone, facsimile, or the most expeditious method available.</p> <p>s. 641.511(6)(c), F.S.</p> <p>An organization shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision, if the initial notification was not in writing.</p>	<p>Review the grievance policy and procedures for the provision in an expedited review, for the organization to notify the subscriber, or the provider acting on behalf of the subscriber, of the decision as expeditiously as the subscriber’s medical condition requires, but in no event more than 72 hours receipt of the request for review.</p>

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<p><u>HMO 74</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>In any case when the expedited review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Subscriber Assistance Program.</p> <p>s.641.511(6)(g), F.S.</p>	<p>s. 641.511(6)(e), F.S.</p>	<p>Review the written policy and procedures for an expedited review of an urgent grievance to verify the inclusion of provisions for the subscriber or the provider acting on behalf of the subscriber to submit a written grievance to the Subscriber Assistance Program in any case when the expedited review process does not resolve the urgent grievance.</p>
<p><u>HMO 75</u></p> <p><u>GRIEVANCE PROCESS</u></p> <p>Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization’s decision concerning the grievance by the Subscriber Assistance Program, as provided in s.408.7056, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must include the addresses and toll-free telephone numbers of the agency and the Subscriber Assistance Program.</p> <p>s.641.511(10), F.S.</p>	<p>An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.</p> <p>s. 641.511(1), F.S.</p> <p>Each organization shall send to the agency a copy of its quarterly grievance reports submitted to the Office of Insurance Regulation pursuant to s.408.7056 (12).</p> <p>s. 641.511(7), F.S.</p>	<p>Review grievance form letters and a sample of grievance response letters for inclusion of information notifying subscribers that they may submit the grievance for review to the Subscriber Assistance Program after receiving a final disposition of the grievance through the organization’s grievance process.</p> <p>Verify that the final decision letter states that the request for review must be made within 365 days after receipt of the final decision letter, explains how to initiate a review, and includes the address and toll-free telephone numbers of the agency and the Subscriber Assistance Program.</p>

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<p><u>HMO 77</u></p> <p><u>INFORMATION DISCLOSURE</u></p> <p>The current list required by section 641.54, F.S., must include the date on which it was prepared or updated.</p> <p>59A-12.011, F.A.C.</p>		<p>Review provider directories to verify that the date on which they were prepared or updated is included.</p>
<p><u>HMO 78</u></p> <p><u>INFORMATION DISCLOSURE</u></p> <p>The organization shall make available to subscribers, upon request, a detailed description of the authorization and referral process for health care services. Any changes in the organization’s authorization and referral process shall be reported to the agency immediately.</p> <p>s.641.54(3), F.S.</p>		<p>Review policies and procedures for making a detailed description of the authorization and referral process available to subscribers upon request.</p> <p>Review the member handbook or the process that the organization uses to notify members that detailed descriptions of the authorization and referral process are available upon request.</p> <p>Review policies and procedures for notifying the agency of any changes in the authorization and referral process.</p>
<p><u>HMO 79</u></p> <p><u>INFORMATION DISCLOSURE</u></p> <p>The organization shall make available to subscribers, upon request, a detailed description of the process used to determine whether health care services are “medically necessary.” Any change in the organization’s definition of “medically necessary” or the process used to determine medical necessity shall be reported to the agency immediately.</p>		<p>Review policies and procedures for making a detailed description of the process used to determine whether health care services are “medically necessary” available to subscribers upon request.</p> <p>Review the member handbook or the process that the organization uses to notify members that detailed descriptions of the process used to determine whether health care services are “medically necessary” are available upon request.</p>

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s.641.54(4), F.S.		Review policies and procedures notifying the agency of any changes in the organization’s definition of “medically necessary or the process used to determine medical necessity.
<p><u>HMO 80</u></p> <p><u>INFORMATION DISCLOSURE</u></p> <p>Each organization shall provide to subscribers, upon request, the following:</p> <ul style="list-style-type: none"> (a) A description of the organization’s quality assurance program. (b) Policies and procedures relating to the organization’s prescription drug benefits, including the disclosure, upon request of a subscriber or potential subscriber, of whether the organization uses a formulary. A subscriber or potential subscriber may also request information as to whether a specific drug is covered by the organization. (c) Policies and procedures relating to the confidentiality and disclosure of the subscriber’s medical records. (d) The decision making process used for approving or denying experimental or investigational medical treatments. (e) Policies and procedures for addressing the needs of non-English speaking subscribers. (f) A detailed description of the process used to examine qualifications of and the credentialing of all providers under contract with or employed by the organization. <p>s. 641.54(5), F.S.</p>		Review policies and procedures for information regarding the quality assurance program, the prescription drug program, confidentiality and disclosure of medical records, experimental or investigational medical treatments, addressing the needs of non English speaking subscribers, and the credentialing process, available to subscribers upon request.
<p><u>HMO 81</u></p> <p><u>INFORMATION DISCLOSURE</u></p> <p>Each health maintenance organization shall make available</p>		1. Review policy and procedures showing how the organization will give the “status” of the

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<p>to its subscribers the estimated co-pay, coinsurance percentage, or deductible, whichever is applicable, for any covered services, the status of the subscriber’s maximum annual out-of-pocket payments for a covered individual or family, and the status of the subscriber’s maximum lifetime benefit. Such estimate shall not preclude the actual co-pay, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate.</p> <p>s. 641.54 (6), F.S.</p>		<p>subscribers information to the subscriber.</p> <ol style="list-style-type: none"> 2. Review certificate of coverage, member handbooks, Internet websites that allow the member to access this information or a process to access the information.
<p><u>HMO 82</u></p> <p><u>INFORMATION DISCLOSURE</u></p> <p>Each health maintenance organization shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05 (3)(1) and shall include in every policy delivered or issued for delivery to any person in the state or any materials provided as required by s. 627.64725 notice that such information is available electronically and the address of its Internet website.</p> <p>s. 641.54 (7), F.S.</p>	<p>s. 408.05 (3)(i): Prescribe standards for the publication of health care related data reported pursuant to this section which ensure the reporting of accurate, valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data reported by or available from the center.</p> <p>s. 627.64725: HMO or EPO; disclosure of terms and conditions – each HMO or EPO shall provide prospective enrollees with written information about the terms and conditions of the plan in accordance with s. 641.31 (4) so that the prospective enrollees can make informed decisions about accepting a managed care system of health care delivery; however, information about where, in what manner, and from whom the comprehensive health care services can be obtained need be disclosed only upon request by the prospective enrollee. All marketing materials distributed by the HMO or EPO must contain a notice in boldface type which states that the information required under this section is available to the prospective enrollee upon request.</p>	<ol style="list-style-type: none"> 1. Review policy and procedures showing how it will make available on its Internet website the information required in this section. 2. Review contracts, member handbooks, certificates of coverage, for instructions on how to access the Agency information.
<p><u>HMO 83</u></p>		<ol style="list-style-type: none"> 1. Review the process for assessing subscriber

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<p><u>INFORMATION DISCLOSURE</u></p> <p>Each organization must establish systems for:</p> <ol style="list-style-type: none"> (1) Assessing subscriber satisfaction with providers, particularly primary care physicians; (2) Sharing subscriber satisfaction indicators and scores with providers; (3) Publicly acknowledging providers with high positive subscriber satisfaction scores; (4) Addressing behaviors of providers with low subscriber satisfaction scores; and (5) Assessing subscriber access and physician availability. <p>s.641.61, F.S.</p>		<p>satisfaction with providers.</p> <ol style="list-style-type: none"> 2. Review the process sharing subscriber satisfaction scores with providers. 3. Review the process used to acknowledge providers with high positive subscriber satisfaction scores. 4. Review the process for addressing behaviors of providers with low subscriber satisfaction scores. <p>Review systems established for assessing subscriber access and physician availability, such as geo-access studies.</p>