

**Health Care District of Palm Beach County  
Coordinated Care Program**



**PROVIDER HANDBOOK**



**HEALTH CARE DISTRICT**  
OF PALM BEACH COUNTY

324 Datura Street, Suite 401 • West Palm Beach, FL 33401  
(561) 659-1270 • Fax: (561) 659-1628 • Fax: (561) 659-4620

**WELCOME TO THE HEALTH CARE DISTRICT OF PALM  
BEACH COUNTY PROVIDER HANDBOOK!**

The Provider Handbook is your resource for information regarding the Coordinated Care Program.

This handbook will assist you in the administration of providing care to Coordinated Care members and provide you with important information on:

- ◆ Claims submission
- ◆ Health plan benefits
- ◆ Referral/authorization processes

You are an important part of our health care delivery system and we look forward to working with you in providing quality health care services to our members.

For additional information or questions about our Plan, please contact your Provider Representative toll free at 1-866-930-1002.

Sincerely,

Dwight D. Chenette  
Chief Executive Officer

Ron Wiewora, MD  
Chief Medical Officer

**HEALTH CARE DISTRICT OF PALM BEACH COUNTY**

**QUICK REFERENCE**

The Health Care District of Palm Beach County is available 8:00 a.m. - 5:00 p.m. Monday through Friday to answer any questions. After hours, you may leave a voice message and a representative will return your call during regular office hours.

<b>Important Numbers</b>				
<b>Department</b>	<b>Telephone</b>		<b>Fax</b>	
Provider Services Department	(866)	930-1002*	(561)	833-9469
Utilization Mgmt. Department (Intake)	(866)	930-7722*	(561)	835-8606
Customer Services Department	(561)	659-7722	(561)	659-7701
	(866)	930-0035*		
	(561)	659-0035		

\* Toll free in Palm Beach County.

<b>Claims</b>
<b>Coordinated Care Program</b>
Health Care District of Palm Beach County Claims Department PO Box 2886 West Palm Beach, FL 33402

<b>General Correspondence</b>
Health Care District of Palm Beach County 324 Datura Street, Suite 401 West Palm Beach, FL 33401-5432
<b>Please indicate the department on the envelope or on the top of the document.</b> (i.e. Provider Services Department, Customer Services Department, etc.)

# Table of Contents

**SECTION 1 - INTRODUCTION.....**

INTRODUCTION..... 1

PURPOSE ..... 1

ORGANIZATION ..... 1

CONFIDENTIALITY STATEMENT..... 1

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)..... 2

**SECTION 2 – ELIGIBILITY GUIDELINES.....**

INTRODUCTION..... 1

PURPOSE ..... 1

ELIGIBILITY GUIDELINES ..... 1

ELIGIBILITY OFFICE LOCATIONS..... 2

CAUSES FOR TERMINATION OF BENEFITS ..... 2

**SECTION 3 – BENEFITS .....**

INTRODUCTION..... 1

PURPOSE ..... 1

EXCLUSIONS ..... 1

DENTAL SERVICES ..... 1

DURABLE MEDICAL EQUIPMENT ..... 3

EMERGENCY ROOM SERVICES..... 4

EMERGENT AND NON EMERGENT TRANSPORTATION SERVICES ..... 5

HOME HEALTH SERVICES ..... 6

HOME INFUSION..... 7

HOSPICE CARE SERVICES ..... 8

INPATIENT ACUTE CARE HOSPITAL SERVICES ..... 9

INPATIENT REHABILITATION SERVICES ..... 10

NUTRITION SERVICES..... 11

ORTHOTICS/PROSTHETICS ..... 12

OUTPATIENT DIAGNOSTIC SERVICES ..... 13

OUTPATIENT REHABILITATIVE THERAPY AND OTHER THERAPIES ..... 14

OUTPATIENT SURGICAL SERVICES..... 15

PRESCRIPTION DRUG SERVICES ..... 16

NON-FORMULARY PRESCRIPTION DRUGS ..... 17

    Drug Replacement program ..... 17

PRIMARY CARE PHYSICIAN SERVICES..... 18

SPECIALTY CARE PHYSICIAN SERVICES ..... 19

VISION SERVICES..... 20

COORDINATED CARE BENEFIT PLAN ..... 21

EXCLUSIONS ..... 22

**SECTION 4 – CUSTOMER SERVICES.....**

INTRODUCTION..... 1

PURPOSE ..... 1

CUSTOMER SERVICES DEPARTMENT ..... 1

MEMBERSHIP ..... 2

    Assignment of Primary Care Physician..... 2

    Change of Primary Care Physician..... 2

    Contacting New Members..... 2

    Eligibility Verification..... 2

    Handling Problem Patients ..... 2

    Membership Card ..... 2

MEMBERS RIGHTS AND RESPONSIBILITIES ..... 3

    Member Complaints ..... 4

**PROVIDER HANDBOOK**

Complaint Process .....4  
Fraud.....5

**SECTION 5 – PROVIDER GUIDELINES.....**

INTRODUCTION ..... 1  
PURPOSE ..... 1  
PROVIDER SERVICES DEPARTMENT ..... 1  
INITIAL CREDENTIALING ..... 2  
ON SITE REVIEW ..... 2  
RE-CREDENTIALING ..... 2  
PARTICIPATING AGREEMENT STANDARDS ..... 2  
MEMBERSHIP LISTING ..... 2  
    Membership Panel ..... 3  
NOTICES OBLIGATION ..... 3  
    Changes in Medical Offices ..... 3  
    Covering Physician – Primary Care Physician ..... 3  
    Malpractice/Liability Coverage ..... 3  
    Non-Participating Physicians/Providers ..... 3  
    Tax ID Number/Address Change ..... 4  
PRIMARY CARE PHYSICIAN GUIDELINES ..... 4  
    Accessibility and Availability Standards – Primary Care Physician ..... 4  
    Acceptable Wait Time ..... 4  
    Telephone Accessibility ..... 4  
    Accessibility Monitoring ..... 5  
CONSULTING SPECIALTY PHYSICIANS GUIDELINES ..... 6  
    Availability and Accessibility – Specialty Physician ..... 6  
    Acceptable Wait Time ..... 6  
    Telephone Accessibility ..... 6  
    Accessibility Monitoring ..... 7  
MEDICAL RECORD REQUIREMENTS ..... 7  
    Documentation Requirements ..... 7  
    Other Related Medical Record Guidelines ..... 8  
ADVANCE DIRECTIVES ..... 9  
    Medical Records Transfers ..... 9  
    Medical Records Charges ..... 9  
CONFIDENTIALITY AND RELEASE OF PATIENT INFORMATION ..... 9

**SECTION 6 – CLAIMS/BILLING.....**

INTRODUCTION ..... 1  
PURPOSE ..... 1  
CLAIMS SUBMISSION ..... 1  
INSTRUCTIONS FOR COMPLETING CLAIM FORMS ..... 3  
    Coding ..... 3  
COORDINATION OF BENEFITS (C.O.B.) ..... 4  
SUBROGATION ..... 4  
PAYMENT ..... 4  
    Payment Methodology ..... 4  
    Payment Reversals ..... 4  
    Physician ..... 5  
    Resubmitting A Claim ..... 5  
REIMBURSEMENT STANDARDS ..... 5  
PAYMENT METHODOLOGY ..... 5  
CRITICAL CARE SERVICES ..... 7  
EMERGENCY DEPARTMENT SERVICES ..... 8  
GLOBAL SURGERY STANDARD – MAJOR SURGERY ..... 8  
GLOBAL SURGERY STANDARD – MINOR SURGERY AND NONINCISIONAL PROCEDURES ..... 10  
PHYSICIAN PATHOLOGY SERVICES ..... 10  
SUPPLIES ..... 10

**PROVIDER HANDBOOK**

REIMBURSEMENT APPEALS OR REQUESTS FOR REVIEW ..... 11  
    Appeals ..... 11  
    Request For Review Of Claim Payment ..... 11  
BALANCE BILLING ..... 12  
REMITTANCE ADVICE ..... 12

**SECTION 7 – QUALITY MANAGEMENT ..... 1**

INTRODUCTION ..... 1  
PURPOSE ..... 1  
GOALS AND OBJECTIVES ..... 1  
QUALITY MANAGEMENT PROGRAM ..... 2  
MEDICAL RECORD REVIEWS ..... 2  
INPATIENT ADMISSIONS REVIEW ..... 2  
MEMBER/PROVIDER SATISFACTION SURVEY ..... 2  
OTHER QUALITY STUDIES ..... 2

**SECTION 8 – UTILIZATION MANAGEMENT ..... 1**

INTRODUCTION ..... 1  
PURPOSE ..... 1  
PREADMISSION REVIEW ..... 1  
CONCURRENT STAY REVIEW ..... 1  
RETROSPECTIVE REVIEW ..... 1  
EMERGENCY ROOM SERVICES ..... 1  
NOTIFICATION OF EMERGENT ADMISSION ..... 2  
SECOND OPINIONS ..... 2  
UTILIZATION MANAGEMENT ..... 2  
    Services Requiring Authorization ..... 2  
PRIMARY CARE PHYSICIAN REFERRAL PROCEDURES ..... 3  
SPECIALTY PROVIDER REFERRAL PROCEDURES ..... 4

**SECTION 9 – RISK MANAGEMENT ..... 1**

INTRODUCTION ..... 1  
PURPOSE ..... 1  
PROVIDER RESPONSIBILITIES ..... 1  
PROVIDER PROCEDURES FOR INCIDENT REPORTING ..... 2

**SECTION 10 - FORMS ..... 1**

INDEX OF FORMS ..... 1

**SECTION 11 - APPENDIX ..... 1**

INDEX OF APPENDIX ..... 1  
DRUG REPLACEMENT PROGRAM ..... 2  
PRIMARY CARE PHYSICIAN GUIDELINES ..... 17  
    Allergy ..... 18  
    Cardiology ..... 19  
    Dermatology ..... 20  
    Endocrinology ..... 21  
    Gastroenterology ..... 21  
    General Surgery ..... 22  
    Gynecology ..... 23  
    Hematology ..... 23  
    Neurology ..... 24  
    Ophthalmology ..... 25  
    Orthopedics ..... 25  
    Otolaryngology ..... 26  
    Pulmonary ..... 27  
    Rheumatology ..... 27  
    Urology/Nephrology ..... 28

***PROVIDER HANDBOOK***

Vascular Surgery .....29  
QUALITY INDICATORS .....30

# SECTION 1 - INTRODUCTION

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## INTRODUCTION

In 1988, the Health Care District of Palm Beach County was established by the Palm Beach County Health Care Act to provide quality, accessible and affordable health care services for Palm Beach County's medically needy. The Health Care District line of business is called the Coordinated Care Program.

## PURPOSE

The Health Care District has established policies, procedures and guidelines to assist in the administration of health care services to its members. This provider handbook outlines those policies, procedures and guidelines.

This handbook is a living document, which will be updated periodically. These updates will be mailed to you and will reflect any modifications to these policies and procedures. Please keep your handbook current.

## ORGANIZATION

This handbook is organized into sections. Sections Two (2) and Three (3) outline specific requirements of Health Care District's Coordinated Care Program. Sections Four (4) through Nine (9) specify requirements for doing business with the Health Care District.

Sample forms are included in Section Ten (10) and the Appendix is located in Section Eleven (11). You can access the Provider Handbook and other online resources at our website: [www.hcdpbc.org](http://www.hcdpbc.org).

If you and/or your office staff have any questions concerning the handbook, please call the Provider Services Department at (866) 930-1002 (toll free in Palm Beach County) or (561) 659-1002.

## CONFIDENTIALITY STATEMENT

It is the policy of the Health Care District that medical records, claims information and grievances pertaining to members and providers will remain confidential. The authorized release of any information is used only for the resolution of medical problems or to enhance the personal health of members. The Health Care District will ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA).



**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT  
(HIPAA)**

In 1996, the U.S. Congress enacted The Health Insurance Portability and Accountability Act, or HIPAA. As its names implies, HIPAA concerns itself principally with changes to make it easier for workers to change employers without losing health insurance coverage. HIPAA also addresses how health information is to be used by participants in the health care system. HIPAA sets standards that certain businesses (covered entities) must follow to ensure that patient information is kept secure and private. It also addresses how health care transactions are to be conducted electronically. As a health plan, the Health Care District is subject to these Federal standards for privacy, security and electronic transfer of health information.

- In accordance with the limitations placed upon it by HIPAA, the Health Care District will only ask for the minimum amount of information necessary to determine eligibility, authorize treatment, review utilization, and perform other plan functions.
- HIPAA permits a covered entity to disclose health information without authorization for treatment, payment and health care operations functions. A provider is therefore permitted to share member health information necessary to receive payment from the Health Care District in accordance with the provider agreement. In addition, a covered entity is permitted to disclose an individual's health information for the operations functions of another covered entity without authorization when both entities have or had a relationship with that individual. Operations functions include activities to improve health and reduce costs, develop protocol, perform case management and care coordination, and related functions. A provider is therefore permitted to share member health information with the Health Care District for utilization review, quality management, and related functions.
- Covered entities are permitted to convey health information by fax machine. Fax machines used for such purposes should be located where access is limited to those whose jobs require it. Fax numbers should be verified periodically. When faxing information to the Health Care District, appropriate staff should be notified to expect it and receipt should be verified.
- Unencrypted electronic files should not be used to convey health information by e-mail or Internet. Such information should be conveyed by fax machine or mail.

## **SECTION 2 – ELIGIBILITY GUIDELINES**

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### **INTRODUCTION**

The Health Care District of Palm Beach County maintains standards for member enrollment. This section summarizes the process for maintaining those standards.

### **PURPOSE**

The purpose of the Eligibility Guidelines are to assist providers in understanding the Health Care District procedures for enrollment and services.

### **ELIGIBILITY GUIDELINES**

Potential recipients for Health Care District coverage must first complete an application for membership into the Coordinated Care Program. Residents of Palm Beach County may visit one of the eligibility offices located throughout the county. Area hospitals may assist applicants in completing applications if there is no valid insurance available, when initially treated in the hospital. The Health Care District's Eligibility Department approves all applications.

The information listed below are some of the measures that the District has in place for eligibility review:

1. Health Care District Eligibility Interviewers reviews the application at the eligibility offices located throughout the county;
2. A welcome packet is sent to each approved member, which identify their benefit plan and explains how to access benefits;
3. Medicaid enrollment is checked on every applicant prior to granting eligibility;
4. Monthly Medicaid reviews are made on the entire Health Care District membership;
5. A maximum eligibility period of 1 year per approval period.
6. Eligibility is not granted to applicants who do not meet Health Care District eligibility requirements.

**ELIGIBILITY OFFICE LOCATIONS**

Listed below are the locations of the eligibility offices where potential recipients may pick up or submit an application:

Belle Glade	1500B N.W. Avenue L Belle Glade, FL 33430 Phone: (561) 992-4255 Fax: (561) 802-3962
Delray Beach	225 South Congress Avenue Delray Beach, FL 33444 Phone: (561) 274-3133 Fax: (561) 802-3963
Lantana/Lake Worth	1250 Southwinds Drive Lantana, FL 33463 Phone: (561) 547-6842 Fax: (561) 802-3964
West Palm Beach	1150 45 <sup>th</sup> Street West Palm Beach, FL 33407 Phone: (561) 514-5390 Fax: (561) 802-3961

\* Applications are also available at [www.hcdpbc.org](http://www.hcdpbc.org)

**CAUSES FOR TERMINATION OF BENEFITS**

The Health Care District will terminate the member’s enrollment for cause. Each situation will be evaluated on an individual basis according to the District’s guidelines. The following are causes for termination:

If the member:

1. Permits someone else to use his/her Health Care District member identification card;
2. Demonstrates disruptive or unruly behavior;
3. Moves outside of the service area;
4. Is admitted or enrolled into a long term care facility, Hospice, Children’s Medical Services, Medicaid Waiver Program, or if he/she is incarcerated;
5. Fails to follow the recommended plan of care;
6. Misses three (3) consecutive appointments within a six (6) month period;
7. Knowingly gives incomplete or false information.

Upon notification the District will send the appropriate notifications to the member to advise them of action being taken. Please call the Customer Services Department at (866) 930-0035 to - notify us of any of these situations.

## SECTION 3 – BENEFITS

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### INTRODUCTION

This section is a summary of benefits available to members enrolled in the Coordinated Care Program. Coverage is limited to those services provided, referred or pre-authorized by the member’s primary care physician and the plan.

### PURPOSE

The purpose of the Benefits Section is to give providers an overview of the plan’s covered services.

### EXCLUSIONS

A list of exclusions can be found in Section 3 pages 22 and 23.

### DENTAL SERVICES

#### *Definition*

Routine dental services include those services that are diagnostic, preventive and restorative in nature for good oral health. All services are provided through the dental clinic at the County Health Department. The Dental Clinic is responsible to refer patients for specialty dental care.

Emergency dental services include those services that are needed for diagnostic and treatment of traumatic injuries, acute infections, and tumors of the oral cavity, jaw and contiguous structures.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"> <li>1. Dental Services must be provided through the Dental Clinic at the County Health Department unless pre-certified.</li> <li>2. One patient/dental provider contact per day, except for emergencies.</li> <li>3. As outlined in the District's Excluded Benefits.</li> </ol>



#### *Eligibility*

- Members who are enrolled in Option 1

#### *Co-payment*

- None

**Palm Beach County Health Department Dental Clinic Locations**

Broadway Health Center	301 Broadway Riviera Beach, FL 33405 Phone: (561) 882-3126
C.L. Brumback Health Center	38754 State Road 80 Belle Glade, FL 33430 Phone: (561) 996-1636
Delray Beach Health Center	225 South Congress Avenue Delray Beach, FL 33444 Phone: (561) 274-3111
Lantana/Lake Worth Health Center	1250 Southwinds Drive Lantana, FL 33462 Phone: (561) 547-6811
West Palm Beach Health Center	1150 45 <sup>th</sup> Street West Palm Beach, FL 33407 Phone: (561) 514-5300

## DURABLE MEDICAL EQUIPMENT

### *Definition*

Durable Medical Equipment includes supplies and equipment that are medically indicated. The request is supported by a signed and dated prescription, plan of care, or statement of medical necessity which includes specific information on the item needed, the duration of the need and the members diagnosis. Equipment maybe rented or purchased, depending on the member's condition and needs.

### *Limitations/Exclusions*

1. All DME and supplies must be pre-certified.
2. The accumulated cost of the rental of DME is not to exceed the purchase price.
3. Equipment not covered by the District:
  - a) Wheelchair accessories such as power attachments, batteries, and battery chargers;
  - b) Specialty wheelchairs, including electric, light weight, heavy duty, custom made equipment, repairs, maintenance or comfort hygiene;
  - c) Walker attachments;
  - d) Patient lifts and supplies;
  - e) Roll about chairs.
4. Comfort items not covered by the District:
  - a) Heating pads, hot water bottles, ice collars, and other hot/cold treatments not primarily for medical benefit;
  - b) Bathroom/bathtub rails and seats;
  - c) Whirlpools and similar devices;
  - d) Items generally used as a complete set, when obtained separately, e.g. Hospital bed frames, mattresses, bed rails, accessories;
  - e) Restraints and related equipment.
5. Devices not covered by the District:
  - a) All hearing aids and devices;
  - b) Artificial kidney machines;
  - c) Routine maintenance or adjustments of devices;
  - d) Home dialysis machines, support devices, cervical pillows or other devices needed/recommended for comfort support.
6. DME and supplies are not covered for members who are patients while in the hospital.
7. Excluded items are those which Medicare has identified as being primarily for patient comfort, convenience and/or hygiene, rather than for true medical treatment or necessity. The Health Care District also excludes those items primarily used in cases of chronic illness or condition.
8. As outlined in the District's Excluded Benefits.

### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## EMERGENCY ROOM SERVICES

### *Definition*

Emergency Room Services are services that are provided by a participating hospital's emergency department for those medical, surgical, hospital, and other related services necessary for the treatment of a sudden and unexpected onset of illness or injury which requires the immediate care and attention of a qualified physician and which, if not treated immediately, would jeopardize or seriously impair the health of a member, or cause loss of life or limb.

Emergency room services include, but are not limited to professional services, medical supplies, diagnostic and therapeutic services, use of hospital facilities, drugs, biologicals, nursing care, and all supplies and equipment necessary to provide appropriate patient care and treatment, in emergency situations.

### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None



## EMERGENT AND NON EMERGENT TRANSPORTATION SERVICES

### *Definition*

Emergent Transportation is Advanced Life Support (ALS) or Basic Life Support (BLS) ground ambulance service to transport a member to a hospital where a member requires services for the treatment of a sudden and unexpected onset of illness or injury which requires the immediate care and attention of a qualified physician and which, if not treated immediately, would jeopardize or seriously impair the health of a member, or cause loss of life or limb.

Non-emergent transportation is to transport a member by ground who is wheelchair or stretcher bound and requires medical attention or treatment.

### *Limitations/Exclusions*

1. Non-emergent ground transport must be provided by a participating provider and pre-certified by the Health Care District and is limited to those members who are wheelchair or stretcher bound.
2. All services must be within Palm Beach County.
3. Any travel or visit allowance for specimen collection is not covered.
4. As outlined in the District's Excluded Benefits.

### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## HOME HEALTH SERVICES

### *Definition*

Home Health Services are medically necessary services which can be effectively and efficiently provided in the home of a homebound member. Homebound is defined as a member who is unable to leave the home without the assistance of another but is not necessarily bedridden. Services can include:

1. Skilled nursing care (RN, LPN)
2. Therapy services (PT, OT, ST, RT)
3. Infusion therapy services

### *Limitations/Exclusions*

1. All services must be pre-certified.
2. All medical and surgical supplies MUST be obtained through Pharmacies located at the various County Health Center locations. For a complete listing please refer to section 3-17.
3. Dialysis supplies are not covered.
4. Enteral and Parenteral Therapy supplies and formula will be reviewed on a case by case basis.
5. Services not covered include personal care aides, home health aides, homemaker services, meals-on-wheels, and Social Services.
6. PT, OT, ST have a combined limit of 30 visits per calendar year.
7. As outlined in the District's Excluded Benefits.

### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## HOME INFUSION

### *Definition*

Home Infusion includes medications or nutritional substances, necessary supplies, and equipment required to infuse. Normally intravenous or intra-arterial administration is used. Home infusion must be coordinated with a home health agency, which will assist with the infusion, training the member, and monitoring the member's progress.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"><li>1. Medications, supplies and equipment must be pre-certified.</li><li>2. As outlined in the Health Care District's Formulary.</li><li>3. As outlined in the District's Excluded Benefits.</li></ol>



### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## HOSPICE CARE SERVICES

### *Definition*

Hospice Care Services include centrally administered, medically directed, nurse-coordinated programs providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his family. It employs an interdisciplinary team to assist in providing palliation and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement. These services are those determined reasonable and necessary for the palliation or management of the terminal illness. In order to receive hospice care a member shall be certified as terminally ill with a life expectancy of 6 months or less. The Health Care District will require a coverage denial from Medicaid or Medicare as related to hospice.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"><li>1. There is a forty-five (45) day inpatient limit per calendar year.</li><li>2. Services will be retrospectively reviewed.</li><li>3. As outlined in the District's Excluded Benefits.</li></ol>



### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## INPATIENT ACUTE CARE HOSPITAL SERVICES

### *Definition*

Inpatient Acute Care Hospital Services include all services provided by a participating network hospital for the medical care and treatment of an inpatient under the direction of a participating physician.

These services include, but are not limited to, room and board, medical supplies, diagnostic and therapeutic services, use of hospital facilities, drugs and biologicals, nursing care, and all supplies and equipment necessary to provide the appropriate patient care and treatment.

The Utilization Management Department shall be notified of all emergent admissions within twenty-four (24) hours of admission or by the end of the next business day.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"> <li>1. All inpatient hospital services must be authorized.</li> <li>2. There is a forty-five (45) day combined limit per calendar year on inpatient hospital care for Health Care District members.</li> <li>3. There is a seven day (7) limit for inpatient hospital care for Health Care District members in the *Retro Plan.</li> <li>4. All inpatient admissions will be followed through concurrent review.</li> <li>5. As outlined in the District's Excluded Benefits.</li> </ol>



### *Eligibility*

- Members who are enrolled in Option 1 and/or Retro plan.

### *Co-payment*

- None

\* Members in the Retro plan are those whose eligibility status was determined subsequent to admission to the facility.

## INPATIENT REHABILITATION SERVICES

### *Definition*

Inpatient Rehabilitation Services include all services provided by a participating network rehabilitation hospital for medical care and treatment on an inpatient basis under the direction of a participating physician. Such services are generally provided by hospitals specializing in the care and treatment of patients requiring rehabilitation for physical conditions or illness, excluding treatment for abuse or addiction to alcohol or substances, or mental illness.

These services include, but are not limited to room and board, medical supplies, evaluation and treatment, use of hospital facilities, drugs, biologicals, nursing care, therapy services, and all supplies and equipment necessary to provide the appropriate care and treatment for rehabilitation of patients.

### *Limitations/Exclusions*

1. All inpatient rehabilitation hospital services must be pre-certified.
2. There is a forty-two (42) day limit per calendar year on inpatient rehabilitation hospital care.
3. All inpatient rehabilitation admissions will be followed through concurrent review.
4. Patient has been assessed to require intensive therapy in two (2) modalities (PT, OT, ST).
5. As outlined in the District's Excluded Benefits.

### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## NUTRITION SERVICES

### *Definition*

Medical Nutrition Therapy services are those services provided by a registered/licensed dietitian. It involves a comprehensive assessment of a patient's overall nutritional status, medical data and diet history, followed by intervention to design a personalized course of treatment. A copy of the Nutrition referral form is provided in Section 10, Forms, of the handbook.

All services are provided by a participating nutritionist at the County Health Department.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"><li>1. Pre-certification is <b>not</b> required for members with a diagnosis of diabetes (Type 2 and gestational) or renal insufficiency.</li><li>2. Pre-certification is required for all other diagnoses.</li><li>3. Authorization is limited to no more than four (4) visits with the nutritionist in a twelve-month period.</li><li>4. As outlined in the District's Excluded Benefits.</li></ol>



### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## ORTHOTICS/PROSTHETICS

### *Definition*

An orthotic is a device such as a brace or orthopedic device that is issued to correct malalignment of a joint for the purpose of protecting or assisting in restoration or improvement of its function.

A prosthetic is the replacement of an absent body part by an artificial substitute, such as an artificial limb. Prosthetic devices are limited to those which assist in mobility or enhance independence in activities of daily living.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"><li>1. All services must be pre-certified.</li><li>2. Adjustment of equipment, artificial devices, dentures or eye wear is not covered.</li><li>3. Member is responsible for repairs, maintenance, cleaning and upkeep.</li><li>4. As outlined in the District's Excluded Benefits.</li></ol>



### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None



## OUTPATIENT DIAGNOSTIC SERVICES

### *Definition*

Outpatient Diagnostic Services are medically necessary and appropriate diagnostic procedures ordered by the member's primary care or specialty physician, and performed at a participating facility.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"><li>1. All PET scans must be pre-certified</li><li>2. As outlined in the District's Excluded Benefits</li></ol>



### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## OUTPATIENT REHABILITATIVE THERAPY AND OTHER THERAPIES

### *Definition*

Outpatient Rehabilitative Therapy Services are services directed to correct functional defects which remain after a catastrophic illness or crippling injury, not including rehabilitation programs for the treatment of abuse or addiction to alcohol or substances, or mental illness. Services include, but are not limited to physical, occupational and speech therapy and must be rendered by a participating facility and/or participating therapist.

Other therapy services include chemotherapy, radiation therapy, hyperbaric treatments, lymphedema therapy, etc. and are used as curative or palliative treatments when medically appropriate for treatment or condition.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"> <li>1. All physical, occupational and speech therapy services must be pre-certified.</li> <li>2. All hyperbaric treatments and lymphedema therapy must be pre-certified.</li> <li>3. Physical therapy, occupational therapy, and speech therapy have a combined limit of thirty (30) treatments per calendar year.</li> <li>4. Maintenance programs and/or chronic conditions are excluded.</li> <li>5. Work hardening programs are excluded.</li> <li>6. As outlined in the District's Excluded Benefits.</li> </ol>



### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## OUTPATIENT SURGICAL SERVICES

### *Definition*

Outpatient Surgical Services include invasive and non-invasive procedures performed in an ambulatory surgical center or hospital outpatient setting, under the direction of a participating physician.

Services include, but are not limited to medical supplies, diagnostic and therapeutic services, use of facilities, drugs, biologicals, nursing care, and all supplies and equipment necessary to provide the appropriate care and treatment of patients.

<b><i>Limitations/Exclusions</i></b>
--------------------------------------

- |   |
|---|
| 1. As outlined in the District's Excluded Benefits. |
|---|

### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None

## PRESCRIPTION DRUG SERVICES

### *Definition*

Prescription Drug Services are medically necessary and appropriate drugs prescribed by the member's primary care physician or specialty physician. Please visit our website at [www.hcdpb.org](http://www.hcdpb.org) to view the most recent version of the Pharmacy Services Drug Formulary. If you do not have access to the internet, please contact the Provider Services Department and a copy will be forwarded to your office.

### ***Limitations/Exclusions***

- All state drug prescriptions must be filled through the Health Care District's pharmacies located at the County Health Department.
- Prescriptions for Family Planning, Sexually Transmitted Diseases or Epilepsy must be written by Health Department physicians and filled only at HCD Pharmacies.
- Non state drug prescriptions must be filled at participating pharmacies in the county.
- The following prescription drugs and over-the-counter drugs must be filled at a Health Care District of Palm Beach County Pharmacy. These include but are not limited to:
  1. Chemotherapy drugs: Prescriptions for oral and subcutaneous medications must be filled at the Health Care District's pharmacies. (Participating oncologists may utilize their own office supply of IV chemotherapy drugs)
  2. AIDS related drugs: Agenerase (Amprenavir), Combivir, Crixivan (Indinavir), Dapsone, Epivir (3TC or Lamivudine), Fortovase (Saquinavir), Hivid (DDC), Invirase (Saquinavir), Lamictal (Lamotrigine), Mepron (Atovaquone), Myambutol, Mycobutin (Rifabutin), Norvir (Ritonavir), Rescriptor (Delavirdine), Retrovir (AZT), Sustiva (Efavirenz), Videx (DDI), Viracept (Nelfinavir Mesylate), Viramune (Nevirapine), Zerit (Stavudine), Ziagen (Abacavir), Zovirax (Acyclovir)
  3. Biotech Drugs: Neupogen, Epogen or Procrit
  4. Immunosuppressant Drugs: Cellcept, Cytovene, Orthoclone OKT3, Prograf, Sandimmune
  5. Miscellaneous Drugs: Aldara, Celebrex, Celexa, LovenoX, Neurontin, Paxil, Protonix Prozac, Pepcid, Risperdal, Seroquel, Serzone, Ultram, Wellbutrin, Zyprexa
  6. Prescription prenatal vitamins when prescribed for a pregnant or lactating female
  7. Oral, mechanical and topical contraceptives
  8. Insulin, disposable needle and syringe combinations, blood glucose test strips, and glucose monitors
  9. Food supplements when prior authorized
  10. Vaginal anti-fungal agents
  11. Smoking cessation products for ages 20 or under
  12. Ferrous sulfate or other iron salts
  13. Prescription strength folic acid
  14. "Sharing The Care" Drugs: Accupril, Cardura, Diflucan, Glucotrol XL, Norvasc, Procardia XL, Zithromax, Zolof, Zyrtec

**PLEASE NOTE: The above list is not complete. Please refer to our Formulary for the most accurate limitations and exclusions to our prescription drug services.**

Health Care District of Palm Beach County pharmacies are located at the following addresses:

<p><b>C.L. Brumback Center</b> 38754 State Road 80 Belle Glade, FL 33430 (561) 996-1637 (phone) (561) 992-6278 (fax)</p>	<p><b>Delray Beach Health Center</b> 225 South Congress Delray Beach, FL 33444 (561) 274-3107 (phone) (561) 265-2593 (fax)</p>
<p><b>Broadway Health Center</b> 301 Broadway Riviera Beach, FL 33404 (561) 882-3193 (phone) (561) 845-1759 (fax)</p>	<p><b>West Palm Beach Health Center</b> 1150 45<sup>th</sup> Street West Palm Beach, FL 33407 (561) 514-5380 (phone) (561) 514-5545 (fax)</p>

**FOR ANY PRESCRIPTION DRUGS NOT LISTED ON THE PREVIOUS PAGE PLEASE REFER THE MEMBER TO THE PROVIDER DIRECTORY FOR A PARTICIPATING PPSC PHARMACY IN THEIR AREA.**

**NON-FORMULARY PRESCRIPTION DRUGS**

Pharmaceuticals not listed on the Health Care District's formulary are not covered.

***Eligibility***

- Members who are enrolled in Option 1, Option 2 and Option 3.

***Co-payment***

- None

If a drug is non-formulary the prescribing physician may file a MD Exception Request by completing a Medical Necessity Form, provided in Section 10, Forms, of this handbook. This form may be copied. A completed form may then be faxed the Director of Pharmacy at (561) 832-4016. The request will be review and you will be contacted with an approval or denial.

***Drug Replacement program***

The Health Care District of Palm Beach County has implemented a Drug Replacement Program. This program is designed for Hematology/Oncology offices that are involved in the administration and infusion of chemotherapy drugs. The delivery services will be conducted by a commercial courier service contracted by the plan at our expense. Please refer to Section 11, Appendix, for replacement of chemotherapy drugs procedures.

## PRIMARY CARE PHYSICIAN SERVICES

### *Definition*

Primary Care Physician Services are those health care services that are provided, coordinated, and/or managed by a network Primary Care Physician (PCP).

Primary care services include periodic medical screening, with a health and development history, unclothed physical exam, developmental assessment, nutritional assessment, updating of routine immunizations, routine laboratory and radiology testing, vision screening, hearing screening, oral assessment, health education; referral for further diagnosis, treatment and therapy indicated by the screening process.

### *Periodic Physical Examinations*

This benefit includes a complete physical examination by a participating Primary Care Physician, which will include the following:

1. Health history (past and present);
2. Family history;
3. List of all known risk factors;
4. Laboratory tests;
5. Nutritional assessment.

These benefits are designed to detect, prevent, and control the progression of disease.

It is the responsibility of the Primary Care Physician to perform necessary and basic diagnostic testing for all District members, prior to referring any patient to a specialty physician.

Prescriptions for Family Planning, Sexually Transmitted Diseases or Epilepsy must be written by Health Department physicians and filled only at HCD Pharmacies.

<i>Limitations/Exclusions</i>
<ol style="list-style-type: none"> <li>1. One health screening (physical exam) every twelve months.</li> <li>2. One patient/physician contact per day, except for emergencies.</li> <li>3. As outlined in the District's Excluded Benefits.</li> </ol>



### *Eligibility*

- Members who are enrolled in Option 1, and Option 2.

### *Co-payment*

- None

## SPECIALTY CARE PHYSICIAN SERVICES

### *Definition*

Specialty Care Physician Services are services provided by a participating specialty physician, who has been asked to provide a specific service by the member's primary care physician and as authorized on the referral form.

The specialty physician will report findings and recommendations back to the member's primary care physician in writing, including a consultation report or office visit notes as the primary care physician is responsible for coordinating all care provided to their patients.

Members requiring prescriptions for Family Planning, Sexually Transmitted Diseases or Epilepsy must be examined and have their prescriptions written by Health Department physicians. These prescriptions can only be filled at HCD Pharmacies.

### *Limitations/Exclusions*

1. All specialty physician services must be pre-certified except dermatology, podiatry, OB/GYN, hematology, oncology and endocrinology for covered services.
2. Specialty physicians should not refer a member to another specialist without approval of the PCP, unless it is within the same specialty or the same diagnosis.
3. One patient/physician contact per day, except for emergencies.
4. As outlined in the District's Excluded Benefits.

### *Eligibility*

- Members who are enrolled in Option 1.

### *Co-payment*

- None

## VISION SERVICES

### *Definition*

Vision Services include necessary visual examination, diagnosis, treatment and management of eye diseases by a participating ophthalmologist or optometrist.

### *Limitations/Exclusions*

1. Vision services must be coordinated with member's primary care physician and be pre-certified as required.
2. Routine eye examination is limited to one per calendar year.
3. One patient/physician contact per day, except for emergencies.
4. Glasses, contacts and eyewear are not covered.
5. As outlined in the District's Excluded Benefits.

### *Eligibility*

- Members who are enrolled in Option 1

### *Co-payment*

- None



**COORDINATED CARE BENEFIT PLAN**

Listed below is a summation of the service(s) that are available for the three options. “X” indicates the service(s) is included under the option. See descriptions on the previous pages for detailed information on the available services.

<i>SERVICES</i>	<i>OPTION 1</i>	<i>OPTION 2</i>	<i>OPTION 3</i>
Dental Services	X		
Durable Medical Equipment	X		
Emergency Room Services	X		
Emergent & Non emergent Transportation Services	X		
Home Health Services	X		
Home Infusion	X		
Hospice Care Services	X		
Inpatient – Acute Care Hospital Services	X		
Inpatient – Rehabilitation Services	X		
Nutrition Services	X		
Orthotics & Prosthetics	X		
Outpatient Diagnostic Services	X		
Outpatient Rehabilitative Therapy	X		
Outpatient Therapy and other Therapies	X		
Outpatient Surgical Services	X		
Prescription Drug Services	X	X	X
Primary Care Physician Services	X	X	
Specialty Care Physician Services	X		
Vision Services	X		

## EXCLUSIONS

1. All costs associated with the collection and preservation of sperm for artificial insemination.
2. Allergy testing and immunotherapy.
3. Alternative and holistic health care services.
4. Ambulance Services.
5. Amniocentesis.
6. Any medical service provided or received outside of Palm Beach County will not be considered for reimbursement by the Health Care District of Palm Beach County unless authorized by the Health Care District.
7. Any patient treated in a hospital while under arrest by, in custody of, being guarded by a law enforcement officer, or under house arrest.
8. Any service provided or received without having been prescribed, directed or authorized by the Health Care District, except in cases of emergency.
9. Any services in connection with education and treatment for learning or developmental disabilities.
10. Bone Stimulators.
11. Care or treatment of anorexia or bulimia.
12. Chelation therapy.
13. Chiropractic treatment or services.
14. Complications related to non-covered services.
15. Cosmetic, medical, surgical, and non-surgical treatments and procedures provided primarily for cosmetic purposes, which shall include but are not limited to: (1) surgery to the upper and lower eyelid; (2) penile implant; (3) augmentation mammoplasty; (4) reduction mammoplasty for male or female or other cosmetic procedures to the breast, (5) removal of breast implants, except in post mastectomy surgery; (6) full or partial face lift; (7) dermabrasion or chemical exfoliation; (8) scar revision, (9) otoplasty; (10) surgical lift, stretch, or reduction of the abdomen, buttocks, thighs, or upper arm; (11) silicone injections to any part of the body; (12) rhinoplasty; (13) hair transplant; and (14) tattoo removal
16. Cost of services performed by another institutional facility while you are hospitalized in a facility.
17. Custodial, domiciliary, convalescent or rest care and care in a skilled nursing facility.
18. Diabetic shoes.
19. Dialysis for chronic renal failure after the 90th day of treatment from first day of dialysis treatment; dialysis treatments within the home.
20. ECP (External Counterpulsation).
21. Experimental medical, surgical or psychiatric procedures and pharmacological regimes that are not generally accepted by the medical community or the Health Care District.
22. External defibrillator vest.
23. Eye glasses or contact lenses.
24. Fertility or infertility testing, artificial insemination or invitro fertilization, embryo transplanted, human chorionic gonadotropin (HCG) injections or reversal of sterilization procedure.
25. Foot care, such as removal of warts, corns, or calluses, including, but not limited to, podiatric treatment of bunions, toenails, flat feet, fallen arches, hammertoes, and chronic foot strain.
26. Gastric stapling, gastric bypass, gastric banding, and other surgical experimental or investigational procedures for the treatment of obesity, weight loss and/or weight management. Diet programs and any variants thereof or exercise programs.
27. Genetic testing, counseling and other related services.
28. Health or beauty aids, or hair analysis.
29. Hearing aids.
30. Immunizations required for travel and physical examinations needed for employment, insurance, or governmental licensing.
31. Joint replacements - limit one (1) per calendar year.
32. Medical or rehabilitation services related to the abuse of or addiction to alcohol, drugs, or other substances.
33. Mental or Behavioral Health services including any services related to the abuse of alcohol, drugs, or other substances.

34. Occupational, physical, and/or speech therapy unless prescribed by a physician and as it relates to a medical condition.
35. Orthodontic services or procedures, periodontal surgery, cast crowns, cast post or core, cast bridges, inlays or onlays, porcelain or resin laminate veneers, space maintainers, implants, or any cosmetic dental procedures.
36. Orthotics (except for joint immobilization).
37. Pain management.
38. Private duty nursing services.
39. Prosthetics - limit one (1) prosthetic per limb per lifetime.
40. Repair of prosthetic or other DME obtained prior to eligibility.
41. Sclera therapy.
42. Services associated with aiding a patient in the home, such as homemaker, domestic or maid service.
43. Services in connection with long term care, chronic care, or nursing home care.
44. Services provided by a family member.
45. Services provided in a hospital setting when the member leaves against medical advice (AMA).
46. Services received as a result of an illegal act. Any injury resulted from being arrested by, in custody of, being guarded by a law enforcement officer or under house arrest.
47. Services received prior to your eligibility effective date or after the termination date.
48. Sex change operations or any sex change related services including services for sexual transformation or sexual dysfunction or inadequacies.
49. Suicide, attempted suicide, or self-inflicted injury.
50. Transplants and any related service to transplants, including transplant donor expenses, or stem cell transplant.
51. Transportation.
52. Travel, whether or not recommended by a physician.
53. Treatment and/or repair of chronic congenital abnormalities.
54. Treatment for acne or non symptomatic lesions, which may include but are not limited to warts, moles, nevi, lipomas, or cysts.
55. Treatment for conditions covered by Workers' Compensation laws.
56. Treatment for military service-connected disabilities for which the Veterans Administration and military hospital system provides care to which the member is legally entitled and when such facilities are reasonably available within the service area.
57. Treatment of Temporomandibular Joint Disease (TMJ).
58. Treatment of varicose veins of the extremities.
59. Urgent care clinic services.
60. Vision training, eye exercises, orthotics, or surgery performed primarily to correct or improve myopia.
61. Wound VAC.

## **SECTION 4 – CUSTOMER SERVICES**

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### **INTRODUCTION**

This section explains general information with respect to membership cards, membership changes, and transfers in the plan.

### **PURPOSE**

The purpose of the Customer Services section is to assist providers with general information about the plan.

### **CUSTOMER SERVICES DEPARTMENT**

Customer Services Department personnel are trained in all aspects of the Health Care District's Plan. Utilize them as a resource for claims questions, eligibility verification or other general information about the Plan.

Customer Services Department personnel are available 8:00 a.m. - 5:00 p.m. Monday through Friday. We are closed from 12:30 to 1:30 each day for lunch but you may leave a message and a representative will return your call. You may contact the Customer Services Department by telephone at (866) 930-0035 or by fax at (561) 659-7701. Please mail all correspondence to the following address:

Health Care District of Palm Beach County  
Customer Services Department  
324 Datura Street, Suite 401  
West Palm Beach, FL 33401-5432

## MEMBERSHIP

### *Eligibility Verification*

A member's eligibility in the Health Care District could change at any time; e.g., member may become eligible for Medicaid. Please call the Customer Services Department to verify enrollment and eligibility of members in the Health Care District prior to rendering service.

### *Assignment Of Primary Care Physician*

Each Option 1 member is responsible for selecting a Primary Care Physician. Consideration in making this selection may include location of the office, member's preferred language, personal referral or community reputation. The choice remains with the member.

### *Change Of Primary Care Physician*

Health Care District member may change Primary Care Physician upon residence change or documented dissatisfaction with services. To change the Primary Care Physician, a member may contact Customer Services by calling (866) 930-0035 to request assistance in selecting another Primary Care Physician or request to change to a participating Health Care District Primary Care Physician. Changes by the member are limited to twice annually.

### *Contacting New Members*

Physicians are encouraged to contact new members. By contacting the new member, the physician can introduce the patient to the educational process of the Plan's benefits and member responsibilities. It can also promote the importance of establishing a medical record.

### *Handling Problem Patients*

Health Care District must to be notified of any members who are non-compliant, become abusive to physicians or their staff or continue to demand health services that do not appear to be medically justified. The District will take the appropriate actions based on the severity of the notification.



### *Membership Card*

Members are issued a Health Care District of Palm Beach County Plan membership card. Members are asked to present the provider with their membership card. A sample of the membership card is provided on page 4-3.

The front of the member's membership card identifies:

- NAME: Indicates the person approved for services.
- MEMBER ID #: This number is issued by the Health Care District and must be used on claims and as it relates to the member.
- DOB: Date of Birth

- **PCP:** Primary Care Physician or the location of the County Health Department where the member receives primary care and where referrals are issued.
- **PCP PHONE #:** Primary Care Physician’s telephone number.
- **PLAN:** Identifies members benefit plan

 <b>HEALTHCAREDISTRICT</b> OF PALM BEACH COUNTY		
NAME		
MEMBER ID		
		DOB
PCP	TEL #	
PLAN	CUSTOMER SERVICE PHONE # 1-866-930-0035	

The back of the member’s Membership card outlines pertinent information for a provider

<p align="center"><b>NOTICE TO PHARMACIES</b></p> <p>Claims should be submitted electronically to: Pharmacy Provider Services Corporation, 3375-I Capital Circle NE, Tallahassee, FL 32308. Call the help desk at 1-800-798-6575 or visit our web site at <a href="http://www.hcdpbc.org">www.hcdpbc.org</a>.</p> <p align="center"><b>NOTICE TO HOSPITALS AND PHYSICIANS:</b></p> <p>This card does not entitle any individual to any benefits unless enrollment status is confirmed. To confirm current benefit status, call the Customer Service number listed on the opposite side of this card. For notification of emergency care, contact the patient’s Primary Care Physician listed on the opposite side of this card. For services requiring authorization, Call 1-866-930-7722. Mail all claims to the address listed in your Provider Handbook.</p>
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## MEMBERS RIGHTS AND RESPONSIBILITIES

The Health Care District is committed to quality health care for all members. Each member has been granted certain rights and responsibilities under this program regarding the provision of services and the management of their health care. A complete copy of the Members Rights and Responsibilities is included in Section 10 – Forms of this handbook.

***Member Complaints***

The Health Care District's representatives will attempt to resolve all member and provider complaints. This process can be initiated by calling the Customer Services Department at (866) 930-0035. Outside of Palm Beach County you must dial (561) 659-0035.

If a member or provider is unhappy with a service received and would like to file a complaint, he/she can do so by calling the Customer Services Department. The following steps will be utilized to help resolve the complaint:

1. A Customer Services Representative will get all the details over the phone.
2. The complaint will be received in the Customer Services Department.
3. All complaints will be forwarded to the Quality Management Department for review and resolution.
4. If the complainant is still not satisfied, he/she may file a formal complaint.

***Complaint Process***

If you are not satisfied with a service you received and would like to file a complaint, you can do so by calling the Health Care District at 1-866-930-0035. A Customer Service Representative will assist you and will attempt to resolve any problems you may have. Your complaint will be reviewed and you will be notified of the decision in a reasonable amount of time.

Customer Services: 1-866-930-7750

Hours and days of operation: Monday – Friday, 8:00 a.m. – 4:30 p.m.

***Fraud***

If you become aware that any potentially fraudulent act has been or is being committed, please notify our office. Fraud is defined as the following:

Intentional misrepresentation, by an individual or entity which results in an unauthorized benefit.

If you have any questions regarding fraud or if you wish to report an area of potential fraud, please call (561) 659-1270 extension 5710, Monday – Friday, 8:00 a.m. – 4:30 p.m. or (561) 659-1270 extension 5300 after hours.



## **SECTION 5 – PROVIDER GUIDELINES**

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### **INTRODUCTION**

The Health Care District of Palm Beach County has established a network of quality physicians to administer health care to its members. This section summarizes the process for maintaining network privileges and establishes guidelines for Primary and Specialty Care Physicians.

### **PURPOSE**

The purpose of the Provider Guidelines is to outline the standards and professional responsibilities of physicians and providers participating with the plan.

### **PROVIDER SERVICES DEPARTMENT**

The Provider Services Department is designed to assist provider offices with the operating policies and procedures of this handbook. A provider representative is assigned to each provider office to assist and ensure compliance with policies and procedures and to coordinate communications between the medical office and the plan.

The Provider Services Department is responsible for the ongoing training and evaluation of the office procedures contained in this handbook.

If you have any questions or require additional information about the Provider Guidelines, contact the Provider Services Department at (866) 930-1002 (toll free in Palm Beach County) or write to the following address:

Health Care District of Palm Beach County  
Provider Services Department  
324 Datura Street, Suite 401  
West Palm Beach, FL 33401-5432

## INITIAL CREDENTIALING

Each physician/provider seeking participation status with the Health Care District of Palm Beach County must submit an application with all the necessary documentation, and a signed provider contract. The application and list of necessary documentation can be obtained from our Provider Services Department. You can access the provider application on our website at [www.hcdpbc.org](http://www.hcdpbc.org).

## ON SITE REVIEW

An onsite office review may be required prior to completion of the credentialing process. This office review will:

1. Evaluate the provider site against the Plan's organizational standards.
2. Evaluate the physician's medical record keeping practices.
3. Ensure the appropriate documentation is posted.

Upon verification of the supporting documentation and completion of the onsite office review, the information is submitted for review regarding participating status with the Health Care District.

## RE-CREDENTIALING

Re-credentialing, a part of the credentialing process, re-verifies the credentialing information of a provider that may have changed over time. Each physician/provider may be re-credentialed every three years. A notification shall be sent to the physician/provider for re-verification of credentialing information. A request for copies of documents may also be required.

## PARTICIPATING AGREEMENT STANDARDS

By signing a Health Care District of Palm Beach County's Participating Agreement, providers are required to comply with all applicable federal and state laws, licensing requirements and professional standards. The Health Care District may exercise its options to terminate a participating provider from the Provider Network with or without cause. Please refer to your Provider Agreement for additional information.

## MEMBERSHIP LISTING

Each Primary Care Physician receives a monthly membership listing by mail. The listing includes basic demographic information about members who have selected the Primary Care Physician as their personal physician. The membership listings are provided for guidance when checking for eligibility of members. Please call the Customer Services Department to verify eligibility of members not on your listing.

### *Membership Panel*

Participating providers are expected to give a thirty (30) day prior written notice to Health Palm Beaches, Inc. when closing or re-opening its membership panel to new and transferring members.

## NOTICES OBLIGATION

The participating provider is responsible for giving the appropriate notices as outlined in this provider handbook and under the participating provider's agreement with the Health Care District.

### *Changes In Medical Offices*

If you add an associate or if an associate leaves your practice, please notify the Provider Services Department immediately. A representative will provide your office with all the necessary information to process the change.

### *Covering Physician – Primary Care Physician*

In the event you are temporarily unavailable or unable to provide care to our members, you should arrange for another contracted and credentialed physician to provide medical service to our members. The physician will provide service to the member pursuant to the terms and conditions of his/her agreement. In the event, you should have a non-contracted physician acting as your covering physician, he/she will be reimbursed at a non-contracted rate and must agree not to balance bill the members.

### *Malpractice/Liability Coverage*

When a physician chooses not carry malpractice coverage, there are certain statutory obligations that must be fulfilled.

Physicians are required to either post a notice in the reception area or provide in a written statement to any person whom medical service is rendered that they do not carry malpractice insurance as defined under Florida Statue, Chapter 458.320 and 459.0085.

If you elect not to carry malpractice insurance, notify your Provider Representative in writing with one week prior to the change

### *Non-Participating Physicians/Providers*

The use of non-participating physicians/providers may be authorized by the plan if the necessary services cannot be provided by a participating physician/provider or if the specialty is not contracted in the network. The request for a non-participating physician/provider must be authorized.

***Tax Id Number/Address Change***

Notify your Provider Representative immediately of any changes in your tax identification number, telephone number, your billing or office address. This will ensure that your practice is properly listed in the Provider Directory and all payments made are properly reported to the Internal Revenue Service.

**PRIMARY CARE PHYSICIAN GUIDELINES**

The Health Care District of Palm Beach County has adopted Primary Care Management Guidelines to be utilized by participating primary care physicians. These guidelines are based on Milliman and Robertson guidelines for Primary Care Management and have been modified to meet the standards of the District.

Please refer to Section 11, Appendix, for a complete listing of these Primary Care Management Guidelines.

***Accessibility and Availability Standards***

The Health Care District has adopted the following service standards regarding the availability of participating physician services. All Primary Care Physicians are expected to maintain the following standards:

**Primary Care Physicians**

<b>Availability and Accessibility of Services</b>	<b>Standard</b>
Emergency	Immediately
Urgent Care	Within One (1) Day
Routine Sick Patient Care	Within One (1) Week
Well Care	Within One (1) Month
Waiting Time in Physician Office for Scheduled Appointment	Less than One (1) hour

Physicians’ services should be available twenty-four (24) hours a day, seven (7) days a week basis with back-up coverage provided by a health care provider.

***Acceptable Wait Time***

Professional evaluation must be provided within one hour of the scheduled appointment time. In the event a delay is unavoidable, the member must be informed and provided an alternative.

***Telephone Accessibility***

As a participating provider you are responsible for assuring that all telephone calls are handled in a courteous and efficient manner. Messages should be triaged, acknowledged and returned by the physician or appropriate staff.

*Accessibility Monitoring*

Compliance with the availability and accessibility standards are monitored on a regular basis through random sampling, review of member complaints and member satisfaction surveys to ensure members have reasonable access to health care providers and services.

**CONSULTING SPECIALTY PHYSICIANS GUIDELINES**

The following outlines the major responsibilities for physicians who participate as consulting specialty physicians in the Health Care District’s network:

1. Provide requested services to Health Care District’s members upon referral by the member’s primary care physician and as pre-certified by Health Care District’s Utilization Management Department;
2. Report findings and recommendations back to the referring primary care physician in writing;
3. Perform or order only those services specifically pre-certified by Health Care District’s Utilization Management Department, and;
4. Follow Health Care District’s Utilization and Quality Management guidelines.

***Availability and Accessibility***

The Health Care District has adopted the following service standards regarding the availability of participating physician services. All specialty physicians are expected to maintain the following standards:

**Specialty Physicians**

Availability and Accessibility of Services	Standard
Emergency	Immediately
Urgent Care	Within on (1) Day
Routine Sick Patient Care	Within One (1) Month
Waiting Time in Physician Office for Scheduled Appointment	Less than One (1) hour

Physicians’ services should be available twenty-four (24) hours a day, seven (7) days a week basis.

***Acceptable Wait Time***

Professional evaluation must be provided within one hour of the scheduled appointment time. In the event a delay is unavoidable, the member must be informed and provided an alternative.

***Telephone Accessibility***

As a participating provider you are responsible for assuring that all telephone calls are handled in a courteous and efficient manner. Messages should be triaged, acknowledged and returned by the physician or appropriate staff.

*Accessibility Monitoring*

Compliance with the availability and accessibility standards are monitored on a regular basis through random sampling, review of member complaints and member satisfaction surveys to ensure members have reasonable access to health care providers and services.

**MEDICAL RECORD REQUIREMENTS***Documentation Requirements*

Medical record documentation is the focus of health care communication and coordination of care. All entries must be dated and signed by the physician or other health care professional. The medical record shall include the quality, quantity, appropriateness and timeliness of services performed. The following standards are required for effective documentation of a member's health care:

1. A separate record is maintained for each patient and is consistent in format for each patient.
2. All records contain identifying information on the member, including name, member identification number, date of birth, sex and legal guardianship.
3. All records must contain HIPPA notification.
4. All records must be legible, maintained in detail, and written in English.
5. All records contain a summary of significant surgical procedures, past and current diagnosis or problems, family medical history (if possible), initial physical, allergies, untoward reactions to drugs and current medication.
6. All entries must be dated and signed.
7. All entries must indicate the chief complaint or purpose of the visit; the objective findings of the practitioner; diagnosis or medical impression.
8. All entries must indicate studies ordered, for example: lab, x-ray, EKG, and referral reports.
9. All entries must indicate therapies administered and prescribed.
10. All entries must include the name and profession of practitioner rendering services, for example: M.D., D.O., O.D., including signature or initials of practitioner.
11. All entries must include the disposition, recommendations, instructions to the patient, evidence of whether there was follow-up, and outcomes of services.
12. Information regarding allergies should be current and in a consistent place within the medical record.
13. All records must contain medications that are prescribed and includes the dosage, amount to be dispensed, instructions, and number of refills.
14. All records must contain an immunization history.
15. All records must contain information on smoking/ETOH (ethyl alcohol)/substance abuse.
16. All records must contain record of emergency care and hospital discharge summaries.

17. All records must reflect the primary language spoken by the member and translation needs of the member.
18. All records must contain documentation that the member was provided written information concerning the member's rights regarding advanced directives (written instructions for living will or power of attorney), and whether or not the member has executed an advanced directive. The provider shall not, as a condition of treatment, require the member to execute or waive an advanced directive in accordance with Section 765.1100, F.S.
19. Records should reflect services provided to members by non-plan providers. Such services must include, but not necessarily be limited to, family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
20. Significant medical advice given to the patient by telephone, whether during or after office hours, should be documented in the patient's medical record and initialed/signed appropriately.
21. Discussions with the patient concerning the necessity, appropriateness, and risks of proposed surgery, as well as discussions concerning treatment alternatives, should be documented in the patient's medical record.
22. All diagnostic, laboratory and consultation reports should be verified by initialing the reports and incorporated in the medical record in a timely manner. Specific treatments instituted or referrals made based on those results should be documented in the medical record.
23. Cancelled or missed appointments showing appropriate follow-up should be documented.
24. To ensure continuity of care, as appropriate, summaries or records of a patient who was treated elsewhere should be obtained.
25. All records must identify members needing communication assistance in the delivery of health care services.

***Other Related Medical Record Guidelines***

The provider site has a system in place that provides for the collection, processing, maintenance, storage, retrieval, and distribution of medical records.

A person in the office is designated as being responsible for medical records. The responsibilities include, but may not be limited to the following:

1. confidentiality, security, and physical safety of medical records;
2. timely retrieval of individual records upon request;
3. the unique identification of each patient's medical record;
4. supervision of the collection, processing, maintenance, storage, retrieval, and distribution of medical records;
5. maintenance of a consistent organized medical record format.

Policies are in place that address the following regarding medical records:



1. retention of active medical records;
2. retirement of inactive records;
3. timely entry of data in medical records;
4. release of information contained in medical records;
5. HIPPA notification contained in medical records.

### *Advance Directives*

Advance Directives are witnessed documents which indicate a patient's choice about their future medical treatment. These documents also allow the patient to designate someone to make decisions about the member's medical treatment should they be unable to make those decisions for themselves. All member records should contain documentation that the member was provided written information concerning the members' rights regarding advanced directives and whether or not the member has executed an advanced directive. A sample of the Advance Directive form is included in Section 10, Forms, of this handbook.

### *Medical Records Transfers*

Upon receipt of a signed Release of Medical Records form by a member, a parent or guardian of a minor, or a personal representative of a deceased member, participating providers must transfer copies of medical records within one week.

### *Medical Records Charges*

Photocopy charges are generally not reimbursable. Please refer to your Provider Agreement for additional information.

## **CONFIDENTIALITY AND RELEASE OF PATIENT INFORMATION**

It is the responsibility of all Health Care District providers to maintain the confidentiality of District member's medical records and health information. A member's medical record may be used for many purposes, however, it is the provider's responsibility to safeguard that information and release it only upon receipt of the member's written permission, except when:

1. information is required by law - subpoena, court order, or other legal process.
2. information is needed to assist another health care provider who is currently involved in the care of the member.
3. information is required by the Health Care District for the purpose of claims payment, quality assessment, and/or utilization review.

## SECTION 6 – CLAIMS/BILLING

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### INTRODUCTION

The Health Care District of Palm Beach County maintains standards for the submission and adjudication of claims. This section summarizes the submission, payment and collection process maintained by the Health Care District.

### PURPOSE

The purpose of the Claims/Billing section is to assist providers in understanding the Health Care District's procedures for claims.

### CLAIMS SUBMISSION

All claims must be submitted to the Health Care District within one hundred eighty (180) days from the date of service. Claims are reimbursed in accordance with contract provisions and rates. Any service not properly authorized or not considered a covered service under the benefit plan shall be denied reimbursement. See Utilization Management section for services which require prior authorization.

Mail all claims to the following addresses:

Health Care District of Palm Beach County  
Claims Department  
P.O. Box 2886  
West Palm Beach, FL 33402-2886

Claims submitted to the Health Care District must be "clean" as defined below. A "clean claim" is an original, accurately completed claim with all necessary information provided. Necessary information may include, but is not limited to medical records, operative reports, etc. Claims which have white out, cross outs, written-over or hand-written information are not considered clean and will not be accepted.

Claims shall be submitted for payment on standard claim forms. The CMS 1500 Form shall be utilized for all non-institutional services and the UB-92 for institutional services. In addition, each claim must satisfy the following:

1. Separate Claim Form for each member;
2. Separate Claim Form for each provider/physician rendering service;
3. Separate Claim Form for each site rendering service;
4. Separate Claim Forms for each authorization received from the Health Care District.

For questions regarding the processing status of a claim, call the Customer Services Department at (866) 930-0035 (toll free within Palm Beach County) or (561) 659-0035. Allow thirty (30) days from the date of submission before requesting status of a claim. Please limit your status requests to three (3) per call. A copy of the Provider Inquiry Form is provided in Section 10, Forms, of this handbook for faxed requests

## INSTRUCTIONS FOR COMPLETING CLAIM FORMS

### *CMS 1500 Claim Form*

1. The Health Care District does not accept HCPCS level III, local Medicare codes/modifiers, or Medicaid codes.
2. Attach a referral/authorization form or enter the referral/authorization number on item 23 of the claim form. An authorization is not a guarantee of payment, payment for services is based upon final adjudication of the claim.
3. Explanation of benefits (EOB) must be attached, which specifically outlines the benefit details from another insurance company, if applicable.
4. Write or stamp “**TRAUMA**” on those claims that are related to patient's trauma incident.
5. Any corrections on procedures billed must be submitted within 30 days of original claim receipt by the Health Care District. An explanation must be included and a copy of the report to support change. If documentation does not support correction, claim will be denied.

### *UB-92 Claim Form*

The following are basic instructions:

1. Current and valid codes (ICD-9-CM, CPT-4, revenue, bill type, etc.) must be used.
2. Explanation of benefits (EOB) must be attached, which specifically outlines the benefit details from another insurance company, if applicable.
3. The proper bill type must be identified on all claims and must correspond to the revenue codes used on the claim.
4. A detailed bill must be attached where a patient has received outpatient therapy over a period of time or each therapy visit must be billed separately.
5. Claim must have notice of determination and copies of reports from patient's medical record for **only** those patients who were not members at the time of admission.
6. Interim bills are not accepted on inpatient admissions, only for outpatient therapy services.
7. Do not submit claims with additional charges, unless the charges will adjust the reimbursement. Additional charges must be submitted within 30 days of the receipt of the original claim.
8. Write or stamp “**TRAUMA**” on those claims that are related to the patient's trauma incident.

The Health Care District follows the criteria set forth by Medicare for billing Medicare Part A. Refer to your Medicare manual for specific and detailed instructions to complete the UB-92.

## CODING

The Health Care District shall accept only standard codes for reimbursement. Procedure codes shall be valid in the current CPT-4 or HCPCS manuals. Diagnosis codes shall be valid in the current ICD-9 CM Manual. A sample of the CMS 1500 Form and the UB-92 Form is provided in Section 10, Forms, of this handbook. Claims received with incorrect codes will be returned to the provider, requesting that the claim be resubmitted with current/valid codes. The claims filing deadline of one hundred eighty days (180) from the date of service will still apply to these claims.

## **COORDINATION OF BENEFITS (C.O.B.)**

The Health Care District shall coordinate benefits with “no fault” auto insurance. The provider/physician shall supply any available information or documentation regarding the Member’s coverage by any other health insurance plan or insurer other than the Plan. Please provide the C.O.B. information in the appropriate section of the claim form. The Health Care District is the payer of last resort.

## **SUBROGATION**

The Health Care District may exercise their right to recover medical expenses from any third party alleged to be legally responsible for bodily injury or illness to a member.

## **PAYMENT**

The Health District shall make payments on properly documented “clean” claims within sixty-(60) days from the date of receipt for Health Care District members. A check accompanied by a remittance advice will be mailed to providers for reconciliation of payments.

Both payments and denials are documented on the remittance advice. All denials include a “not covered reason”. An explanation of all codes appears on the last page of the remittance advice.

### *Payment Methodology*

The Health Care District reimburses physicians using the Medicare fee schedule, which is based on the Medicare rate in effect on January 1<sup>st</sup> of the contract year. Physicians are reimbursed according to the amount outlined within the physician agreement. The Health Care District reimburses all other providers as specified in their provider agreement. Refer to the agreement for specific reimbursement details.

***The Health Care district will only reimburse providers. Members cannot submit bills to the Health Care District for payment.***

### *Payment Reversals*

The Health Care District routinely audits provider claim payments within 1 year of the date of service. If the Health Care District determines that an inappropriate payment has been made, a reversal of the payment will be made on the total claim or on an individual detail line.

The Health Care District shall submit a written request to the provider/physician. Provider/physician must contest in writing the written request within thirty-five (35) days of the notification. The provider must pay or deny the claim for overpayment within forty-five (45) days of the receipt of the written request.

The reversal of payment can be reduced by future claim payment. A letter must be submitted to the Health Care District requesting future payment be utilized to reduce the reversal. The reversal will be indicated on the provider’s remittance advice along with the reason for the reversal under the adjustment reason heading.

**PHYSICIAN**

The Health Care District reimburses physicians using the Medicare fee schedule, which is based on the RBRVS (Medicare) rate in effect on January 1<sup>st</sup> of the contract year. Physicians are reimbursed according to the amount outlined within the physician agreement.

**RESUBMITTING A CLAIM**

If after 60 days from the date the claim is mailed, providers may resubmit claims if they have not received:

1. A payment or notice of denial.
2. A letter requesting further information.
3. A letter stating that the claim is under review.

**Do not resubmit a claim if it has been paid or denied.** The Health Care District's computer system will identify the claim or detailed line as a duplicate and the claim will be denied.

*Anesthesiology Services*

Anesthesia is billed using CPT codes 00100 to 01999. Time as measured by actual presence with the patient, beginning when the patient is prepared for anesthesia in the operating room and ending when continual attendance is not required (patient is placed under postoperative supervision). For reimbursement purposes, time is divided into units, with fractions of units rounded up to the nearest half-unit.

Anesthetics reimbursement is based upon the following equation:

Anesthetic base units + anesthetic time = contracted payment rate

EXAMPLE:

Appendectomy – CPT-4 codes 44950

Anesthetic base unit – 6 units

Anesthetic time – 2 hours (8 units)

Payment per unit - \$25.00

$$(6 + 8) \times \$25.00 = \$350.00 \times 80\% = \$280.00$$

Reimbursement - \$280.00

NOTE: This is an example only. Unit values change as fee schedules change.

A separate payment is made to for specialized services, such as insertion of Swan-Ganz catheters, intra-arterial lines and central venous pressure lines.

Post-surgical pain management is considered to be managed by the surgeon, and therefore included in the global surgical fee. Separate payment will not be allowed for an anesthesiologist unless medically justified.

The Health care District's will only reimburse a global payment to either the anesthesiologist or the certified registered nurse anesthetists.

***Consultations***

A consultation is a service furnished by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source.

However:

1. The choice of an appropriate consultation code is dependent on the place of service and/or whether it was an initial or follow-up consultation.
2. The only category of consultation codes that are not place of service specific is confirmatory consultation.
3. The consultant *may initiate* diagnostic or therapeutic services, *but cannot take over* the control of the medical management.
4. When the physician is transferring the patient's care (total or a specific portion of), consultative codes are not used.
5. If a consultant subsequently assumes responsibility for management of a portion or of all of a patient's condition(s), the consultation codes should not be used. In a hospital setting, the physician receiving the patient for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In an office setting, use the appropriate established patient code. A copy of the order requesting consultant to take over the management of the patient must be attached to the claim.

6. Any separately identifiable procedures performed on or subsequent to the date of the initial consultation should be reported separately.

### *Surgery Assist*

Under the Health Care District fee structure, the payment for an assistant at surgery is 16% of the allowable for the surgical code. Modifier 80 or 81 must be used to identify an assistant surgeon, and the procedure code billed must warrant assistant at surgery services.

## CRITICAL CARE SERVICES

Care of critically ill patients includes a variety of medical emergencies that require the constant attention of a physician.

Critical care codes are used to report the total time spent by a physician providing constant attention to a critically ill patient.

The total amount of time reported each day need not be continuous time.

Code 99291 is used to report the first hour of critical care on a given day. Code 99292 is used for each additional 30-minute increment.

- 99291: Critical care evaluation and management of the critically ill or critically injured patient, requiring the constant attendance of the physician; first 30-74 minutes.
- 99292: Each additional 30 minutes.

Follow-up care not requiring constant attention of the physician should be coded as subsequent hospital inpatient visits.

Critical care includes caring for critically ill patients in a variety of medical emergencies that require the constant attention of a physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications). Critical care is usually, but not always, given in a critical-care area, such as the coronary-care unit, intensive-care unit, respiratory-care unit, or the emergency-care facility. Critical care includes cardiopulmonary resuscitation and a variety of services attendant to this procedure, as well as other acute emergency situations. Services for a patient who is not critically ill in a critical-care unit are reported using subsequent hospital-care codes.

Services performed during the critical period (e.g., placement of catheters, cardiac output measurement, tube thoracostomy, control of gastrointestinal hemorrhage, electrical conversion of arrhythmia, endotracheal intubation, management of mechanical ventilation, blood gas monitoring) are included in reporting 99291, 99292.

Other procedures that are not directly attendant to critical-care management (e.g., the suturing of lacerations, setting fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap) are not included in critical care and should be reported separately.



The Health Care District reimburses only one physician who charges for critical care, for a specified time.

## EMERGENCY DEPARTMENT SERVICES

The emergency department must be a hospital-based facility that provides unscheduled episodic services to patients who require immediate attention. The facility must be available 24 hours a day. The Health Care District will *only* accept requests for physician payment on a CMS 1500 Form.

## GLOBAL SURGERY STANDARD – MAJOR SURGERY

The global surgery standard includes pre-operative visits the day before surgery, the day of surgery, the hospital admission work-up, the primary operation, immediate post-operative care including dictating operative notes, talking with the family and other physicians, writing orders, evaluation of the patient in the recovery room, post-operative follow-up the day of surgery, and post-operative hospital and office visits.

1. Initial evaluation/consultation:
  - a) Initial evaluation or consultation by a surgeon is paid separately from the global surgery package if the consultant does not perform the surgery.
2. Preoperative visits:
  - a) No separate payments are made to the surgeon for preoperative visits in or out of the hospital beginning the day before the surgery. A preoperative period of one day is a part of the global surgery standard.
3. Intraoperative services:
  - a) No separate payments are made for usual and necessary intraoperative services required for completion of the surgery.
4. Complications following surgery:
  - a) No separate payment is made for additional medical and surgical services resulting from complications that do not require a return to the operating room. All medically necessary return trips to the operating room, for any reason and without regard to "fault", are separately billed and paid for, but at a reduced rate. Re-operations to deal with complications are set at the value of the intraoperative services being performed, if there is a CPT code to describe the services.
5. Postoperative visits:
  - a) No separate payment is made for postoperative visits up to 90 days after the date of surgery.

**Included in the global fee are services such as, but limited to, dressing changes, local incision care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary**

**catheters, routine peripheral intravenous lines and nasogastric and rectal tubes; and change and removal of tracheotomy tubes.**

Separate payment is made for a visit to the surgeon for a problem unrelated to the surgery, or a course of treatment other than normal recovery from surgery.

## GLOBAL SURGERY STANDARD – MINOR SURGERY AND NONINCISIONAL PROCEDURES

Procedures included under this category are some diagnostic and therapeutic endoscopic procedures that may or may not involve actual surgery. Also included are the “scopies”, which are diagnostic and therapeutic procedures frequently performed by non-surgeons and may or may not involve surgery. These relatively minor surgical services are not traditionally paid using a global surgery policy.

No separate payment will be made for a visit on the same day as the procedure, unless unrelated to or separately identifiable from the procedure.

1. Postoperative visits:
  - a) Minor surgeries have a postoperative period of either zero or 10 days.
  - b) Those with 10 days include all services related to recovery from the surgery. Services provided during a 10 day postoperative period for an underlying or unrelated condition will be paid separately.
  - c) There are zero postoperative days for endoscopic procedures performed through an existing body orifice. Incisional scope procedures (i.e., laparoscopic cholecystectomy) are subject to either the 10 or 90 day postoperative period, depending upon the complexity.

## PHYSICIAN PATHOLOGY SERVICES

In 1992 HCFA identified approximately 57 CPT codes for physician pathology services. The remainder of the 88000 code section is considered to be clinical laboratory services. The Health Care District reimburses pathologists according to the payment status set forth in the Federal Register. The Federal Register has identified specific pathology and laboratory codes where no professional component is allowed.

## SUPPLIES

No separate payment is made for office medical supplies routinely furnished by physicians. Included under this exclusion are supplies used in laceration repair and supplies used to administer chemotherapy. This is considered to be a part of the practice expense.

### *Surgery Assist*

Under the Health Care District fee structure, the payment for an assistant at surgery is 16% of the allowable for the surgical code. Modifier 80 or 81 must be used to identify an assistant surgeon, and the procedure code billed must warrant assistant at surgery services.

**REIMBURSEMENT APPEALS OR REQUESTS FOR REVIEW**

If a provider believes that a claim was not reimbursed appropriately, an Appeal or Request for Review may be filed. Appeals or Requests for Review must be filed within thirty (30) days from the check date or date of remittance advice.

***Appeals***

Providers may appeal the medical decision effecting a claim payment by completing an Appeal form. A sample of the Appeal form is provided in Section 10, Forms, of this handbook. Along with the Appeal form, the provider is responsible for submitting all necessary information to re-evaluate the medical decision. Additional information may include but is not limited to:

1. Copy of remittance advice;
2. Copy of clinical information to determine medical necessity;
3. Copy of medical records;
4. Copy of referral or authorization.

Mail appeals to the following address:

Health Care District of Palm Beach County  
Attn: Appeals Department  
324 Datura Street, Suite 401  
West Palm Beach, FL 33401-5432

\* All Appeal decisions are final \*

***Request For Review Of Claim Payment***

Providers may request a review of a claim payment by completing a Request for Review form. A sample of the Request for Review form is provided in Section 10, Forms, of this handbook. These reviews are appropriate for claims that do not require review of medical records or criteria. (I.e. duplicate claim denials, unbundling, incorrect CPT coding or diagnosis, etc.) Along with the Request for Review form, the provider is responsible for submitting all necessary information to re-evaluate the reimbursement decision. Additional information may include but is not limited to:

1. Copy of remittance advice;
2. Copy of referral or authorization.

Please do not submit duplicate copies of bills with your Request for Review. Denials for incorrect coding (place of service, ICD-9, CPT-4, etc.) or missing documentation may be resubmitted directly to the Claims Department as long as they are within the filing time limits.

Requests for Review are to be faxed to the following number:

**CLAIMS DEPARTMENT (561) 659-7701**

Please allow 30 days for a response before following up for review status. An Acknowledgement Notice will be faxed to all providers requesting reviews within 48 hours of receipt by the Health Care District. This notice will list the claimants and claim numbers we have received for review. Inquiries submitted incorrectly on the Request for Review forms will be returned to the providers to submit an Appeal.

**\*All Appeal decisions are final\***

**BALANCE BILLING**

Payments made by the Health Care District of Palm Beach County are considered in full for services rendered. Providers may not balance bill members of the Health Care District of Palm Beach County for any covered service. This is outlined in the provider agreement under Compensation.

**REMITTANCE ADVICE**

The Health Care District makes payments on properly documented “clean” claims within sixty (60) days from the date of receipt. A check accompanied by a remittance advice will be mailed to providers for reconciliation of payments. A copy of the remittance advice and instructions on how to read the information is available at the end of this chapter.

## **SECTION 7 – QUALITY MANAGEMENT**

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### **INTRODUCTION**

The Quality Management Program is designed to effectively measure, assess and improve the care and services provided to members of the Health Care District. This Program demonstrates our commitment to quality improvement by establishing strict guidelines and dedicating the resources necessary to accomplish all aspects of the quality improvement process.

### **PURPOSE**

The purpose of the Quality Management Program is to monitor that members are provided high quality health care in an environment of minimal risk. The Program addresses both patient care and customer satisfaction in order to ensure that members are provided high quality and efficient services from participating providers and employees of the Health Care District.

### **GOALS AND OBJECTIVES**

The objectives to be satisfied under this plan are as follows:

1. Design a system for identifying issues in quality of care or quality of services by plan personnel, providers and members.
2. Establish a systematic, ongoing process of objective evaluation of patient care and services.
3. Establish priorities for investigation, tracking and resolution of identified problems.
4. Develop a documentation system for reporting quality management findings, implementation, follow-up and results.
5. Promote the coordination, documentation and communication of plan-wide quality improvement activities.
6. Establish a mechanism for implementing, tracking and following up quality improvement activities.
7. Promote compliance by network providers with defined standards of care which include access, medical record documentation and practice guidelines for prevention and treatment.
8. Improve operational systems to provide optimum care in a cost effective manner.
9. Establish a process that will identify and evaluate urgent situations requiring immediate action.
10. Ensure that the organization is efficient in accomplishing its goals and objectives.

## **QUALITY MANAGEMENT PROGRAM**

The Health Care District maintains an ongoing quality improvement program to objectively monitor and evaluate the quality and appropriateness of health care services provided to members. The program evaluates opportunities for improvement of general health and health outcomes through a process of continuous quality improvement. To help achieve the Health Care District's goal, quality of care reviews will include the following:

### **MEDICAL RECORD REVIEWS**

To help achieve the Plan's goal, quality of evaluations will be conducted through the process of medical record review. The plan shall conduct quality of care evaluations which:

1. Target specific conditions and specific health service delivery issues for focused individual practitioners and system-wide monitoring and evaluation.
2. Use clinical care standards or practice guidelines to objectively evaluate the care the provider delivers or fails to deliver for the targeted clinical conditions.
3. Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

These medical records shall also be reviewed as to the completeness of the documentation. These findings will then be reviewed and recommendations will be communicated with the Primary Care Physician.

### **INPATIENT ADMISSIONS REVIEW**

The Health Care District shall utilize quality screens to identify any potential issues of care identified through the concurrent stay review process. These quality screens may include issues such as delay in treatment, inappropriateness of the care provided, and/or readmission within thirty days. Please refer to Section 11, Appendix for a listing of the Quality indicators.

### **MEMBER/PROVIDER SATISFACTION SURVEY**

The Plan may conduct member and provider surveys.

### **OTHER QUALITY STUDIES**

The Plan strives to take an active role in improving our members' health status by making available preventive health services. As a result, preventive reviews may be conducted to determine compliance with professionally agreed upon health care maintenance standards.

## **SECTION 8 – UTILIZATION MANAGEMENT**

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### **INTRODUCTION**

The Utilization Management Program is committed to serving the members in an efficient and cost-effective manner and provides access to quality health care services.

### **PURPOSE**

The purpose of the Utilization Management Program is to establish a structure to monitor that members receive health care services in the most appropriate setting for emergency care, urgent care, routine care, and non-symptomatic routine care.

The Utilization Management Program utilizes Pre-admission Reviews, Concurrent Reviews and Retrospective Reviews to evaluate and monitor health care services.

### **PREADMISSION REVIEW**

Pre-admission review is the process to assure that all inpatient services are medically appropriate for the admission or service and to assess that an inpatient level of care is required.

All elective medical and surgical admissions require pre-admission review by the Plan's Utilization Management Department.

### **CONCURRENT STAY REVIEW**

Concurrent stay review is the process whereby the Plan is in contact with the Hospital's Utilization Review Department and/or the Physician's office to assure that the medical services being provided to the member can only be provided in an inpatient setting.

### **RETROSPECTIVE REVIEW**

Retrospective review is the process performed on those health care services after the service has been rendered. The goal of this review process is to determine the medical necessity for the admission or service and to assess the acuity of the patient's level of care.

### **EMERGENCY ROOM SERVICES**

Emergency Room Services do not require pre-certification. Members who feel they are experiencing a medical emergency should be instructed to go to the nearest emergency room.



## **NOTIFICATION OF EMERGENT ADMISSION**

The Utilization Management Department should be notified of all emergent admissions within 24 hours of admission or by the end of the next business day. These admissions will be reviewed based on the Plan's approved guidelines and inpatient criteria.

## **SECOND OPINIONS**

A second opinion may be requested in any instance in which a member reasonably disputes the determination or medical necessity of a surgical procedure or if a member has been diagnosed as suffering from a serious injury or illness.

The second opinion, if requested, may be obtained from a physician chosen by the member but subject to the following restrictions:

1. A physician may be selected from the Provider Directory. The member will have no financial obligation. These services must be requested by the member's primary care physician.
2. If a member selects an out-of-network provider, the request requires prior approval from the Plan. If the Plan approves the out-of-network provider, the Plan cannot guarantee that the provider will not impose additional financial obligations on the member. If the Plan does not approve the out-of-network provider, the member will have full financial obligation for these services.

When a second opinion does not confirm the original recommendation, the member may request a third opinion. These services will be covered in the same manner as the second opinion.

## **UTILIZATION MANAGEMENT**

The following Utilization Management information is designed to assist providers with understanding specific guidelines for Health Care District.

### **SERVICES REQUIRING AUTHORIZATION**

The following services require authorization by the Health Care District's Utilization Management Department:

1. All hospital admissions
2. All inpatient rehabilitation admissions
3. All specialty physician office visits (except OB/GYN, Podiatry, Dermatology, Endocrinology, Hematology/Oncology for covered services by participating providers.)
4. Durable Medical Equipment
5. Dialysis
6. Home Health Services

7. Home Infusion Services
8. Hyperbaric Oxygen Therapy
9. Non-Emergent Transportation
10. Penicillin Allergy Testing
11. Pet Scans
12. Orthotics/Prosthetics
13. Outpatient Therapy
14. Referrals to out of network providers
15. Wound Care Centers

The following services **do not** require pre-certification if prescribed by the primary or specialty physician, are medically necessary and provided by a participating provider:

1. Dermatology
2. Diagnostic procedures (except Pet Scans)
3. Endocrinology
4. Hematology/Oncology
5. Laboratory Work
6. OB/GYN
7. Outpatient Surgery
8. Podiatry

Once the patient is referred to a specialist by the Primary Care Physician, any further office visits or procedures by the Specialist may be requested by the Specialist's Office.

## **PRIMARY CARE PHYSICIAN REFERRAL PROCEDURES**

When a Primary Care Physician determines that a Health Care District member is in need of a health care service or procedure that requires a referral to a specialist or ancillary provider prior authorization must be obtained from the Health Care District's Utilization Management Department. To obtain authorization the Primary Care Physician needs to complete a Referral Form. A sample is provided in Section 10, Forms, of this handbook. Fax all forms to (561) 835-8606. Please note that clinical information to support the medical necessity of the requested service will be required for all requests. All routine requests must be received at least seventy-two (72) hours prior to the service date.

If a Primary Care Physician determines that the requested service is urgent or needs the attention of the Medical Director, a telephone call should be directed to the Intake line at (866) 930-7722 to ensure that the request is handled in a timely manner.

**Upon receipt, the request for authorization will be reviewed and a response will be faxed within seventy-two (72) hours to the requester and provider of service with the decision to approve or deny reimbursement for the requested service.**

The Primary Care Physician staff will need to make the necessary arrangements for the member's appointment and notify the member of the scheduled appointment.

## **SPECIALTY PROVIDER REFERRAL PROCEDURES**

If a Specialty provider determines that a Health Care District member is in need of a related health care service or procedure that requires prior authorization, the Specialist must seek prior authorization from the Health Care District's Utilization Management Department. The authorization can be obtained by completing a Referral form. A sample of the Referral Form can be found in Section 10, Forms, of this handbook. Fax all forms to (561) 835-8606. Please note that clinical information to support the medical necessity of the requested service will be required for all requests. All routine requests must be received at least seventy-two (72) hours prior to the service date.

If a Specialty provider determines that the requested service is urgent or needs the attention of the Medical Director, a telephone call should be directed to the Intake line at (866) 930-7722 to ensure that the request is handled in a timely manner.

**Upon receipt, the request for authorization will be reviewed and a response will be faxed within seventy-two (72) hours both to the referring physician and to the provider of the service with a decision to approve or deny reimbursement for the requested service.**

The specialty provider will be responsible to make all necessary arrangements for the requested service and to notify the member and the Primary Care Physician of all appointments and necessary arrangements. The specialty provider is also responsible for providing the Primary Care Physician with all consultation notes and medical reports that are a result of the health care service. This medical information is needed to complete the member's medical record retained by the Primary Care Physician.

## SECTION 9 – RISK MANAGEMENT

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### INTRODUCTION

The Health Care District of Palm Beach County Risk Management recognizes the importance of minimizing risks to members in the provision of health care services. To minimize risks, The Health Care District of Palm Beach County employs a formal Risk Management Program.

### PURPOSE

The purpose of the Risk Management Program is to objectively monitor, evaluate and correct situations that may occur in the administration and delivery of health care services.

### PROVIDER RESPONSIBILITIES

Providers must report all incidents involving members, which occur in a clinical setting to the Risk Manager. The following is a listing of those types of “incidents” that would require reporting to the Risk Manager:

The State of Florida legally defines “adverse or untoward incident” as an event over which healthcare personnel could exercise control and:

1. Is more probably associated in whole or in part with medical intervention rather than the condition for which such intervention occurred; and
2. Is not consistent with or expected to be a consequence of such medical intervention; or
3. Occurs as a result of medical intervention to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the facility or personnel or the facility; or
5. Results in a surgical procedure unrelated to the patient’s diagnosis or medical needs being performed on any patient; and
6. Causes injury to a patient. Injury is defined as any of the following outcomes when caused by an adverse incident:
  - a) Death or;
  - b) Brain damage or;
  - c) Spinal damage or;
  - d) Permanent disfigurement or;
  - e) Fracture or dislocation of bones or joints; or
  - f) A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility; or

- g) Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or
  - h) Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident; or
  - i) Was the performance of a surgical procedure on the wrong patient; or
  - j) A wrong surgical procedure; or
  - k) A wrong-site surgical procedure; or
  - l) A surgical procedure otherwise unrelated to the patient's diagnosis or medical condition; or
  - m) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or
  - n) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.
  - o) Nosocomial or hospital acquired infections that require particular and possibly specialized medical attention.
7. Any adverse or untoward incidents occurring in a physicians office that results in the following must be reported to the Risk Management Department within 24 hours of the occurrence:
- a) The death of a patient; or
  - b) Severe brain or spinal damage to a patient; or
  - c) 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.
  - e) Nosocomial or hospital acquired infections requiring treatment involving a surgical procedure.

## PROVIDER PROCEDURES FOR INCIDENT REPORTING

1. The Risk Management Incident Report form is to be completed for all incidents with actual or potential injury to Health Care District members. The Report is to be submitted to the Risk Manager within three calendar days.
2. If the incident involves an injury, the Risk Manager is to be notified within 24-hours of the incident by calling (561) 659-1270. Ask for the Risk Management Department. If the original Incident Report indicated no injury or no significant injury, but later examination reveals an injury was sustained, immediately notify the Risk Manager.
3. The Incident Report shall be signed by the physician and the person filing the report. The personnel involved with the incident shall be identified; however, the report does not have to be completed by them. The form is completed in its entirety. If sections are not applicable, enter "n/a". It is important the report is promptly sent to the Risk Manager at 324 Datura Street, Suite 401, West Palm Beach, FL 33401-5432.

4. The relevant facts of the incident should be documented in the medical record. The description of the incident should be clear and concise. Assumptions should not be made.

A sample of the Risk Management Incident Report is provided in Section 10, Forms of this handbook.

## **SECTION 10 - FORMS**

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### **INDEX OF FORMS**

#### **ADVANCE DIRECTIVES**

- Florida Designation of Health Care Surrogate
- Florida Living Will Declaration

#### **GRIEVANCE FORM**

#### **MEMBER RIGHTS AND RESPONSIBILITIES**

#### **NUTRITION REFERRAL PROCESS**

#### **NUTRITION REFERRAL FORM**

#### **PROVIDER INQUIRY FORM**

#### **REFERRAL FORM**

#### **REQUEST FOR APPEAL**

#### **REQUEST FOR NON-FORMULARY DRUG OF MEDICAL NECESSITY**

#### **REQUEST FOR REVIEW ACKNOWLEDGEMENT NOTICE**

#### **REQUEST FOR REVIEW OF CLAIM PAYMENT**

#### **RISK MANAGEMENT INCIDENT REPORT**

## Health Care District of Palm Beach County

# ADVANCE DIRECTIVES

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The following information is provided to you by the Health Care District of Palm Beach County in accordance with the *Patient Self-Determination Act* and Florida State law. Under this act, you have the right to make decisions concerning your medical care, including your right to accept or refuse treatment. The goal in creating an *advance directive* is for your wishes to be clearly stated so the health care facility, physician and whoever else may be involved with carrying out your wishes, know what you would want. There is no requirement that you have an *advanced directive*.

The following explains the policy of the Health Care District of Palm Beach County with respect to *advance directives*. This information is general and is not intended in any way as legal advice.

“*Advance directives*” are witnessed documents which indicate your choices about your future medical treatment and also allow you to designate someone to make decisions about your medical treatment should become unable to make these decisions or choices yourself. An *advance directive* can address such issues as whether to provide any and all health care, including extraordinary life prolonging procedures, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care provider should consult when making treatment decisions.

Under Florida law, an individual has the right to decide the type, amount and duration of the health care treatment he or she receives. The Florida legislature has sought to make it easier for each individual to make his or her desires known and to be able to control the course of his/her treatment.

In the event you are unable to speak for yourself and you have not made an *advance directive*, Florida law states your physician or other health care providers are authorized to look to the following people in the order listed for decisions about your care:

1. Your guardian, if a court has appointed one;
2. Your spouse;
3. An adult child, or a majority of adult children who are reasonably available for consultation;
4. Either of your parents;
5. An adult brother or sister, or a majority of those who are reasonably available for consultation;
6. An adult relative who has exhibited special care or concern for you and who is familiar with your activities, health, and religious or moral beliefs;
7. A close friend who is an adult and has exhibited special care and concern for you and who is familiar with your activities, health, and religious or moral beliefs.

There are two types of *Advance Directives* authorized under Florida law. They are: a *Living Will* and a *Healthcare Surrogate Designation*.



A *Living Will* is a formal statement indicating the individual's desire that life-prolonging procedures be provided, withheld, or withdrawn in the event the individual is unable to express his or her wishes. It does not become effective until the patient's physician and one other physician determine the patient suffers from a terminal condition and is not capable of making decisions.

A *Healthcare Surrogate Designation* grants authority to the surrogate (a person predetermined by the patient) to make health care decisions for the patient in accordance with the patient's wishes.

The surrogate's authority is limited to what the patient's wishes would be if he/she were able to communicate those wishes and to the time when the patient is incapacitated. The surrogate's power to make decisions should be clearly expressed in the document, including and limitations. By law, there are some decisions the surrogate cannot make.

Making an *advances directive* is a personal choice and it may be helpful to discuss your decision with your spouse, family members, friends, physician, and religious or spiritual advisor. The Health Care District of Palm Beach County and your health care provider cannot condition your treatment on whether or not you have made an *advance directive*.

It is the member's responsibility to notify his or her physician that an *advance directive* has been made. A copy of the *advance directive* should be sent to your physician, so that it becomes a part of your medical record.

If you have questions concerning *advance directives*, contact the Health Care District of Palm Beach County Customer Services Department at (866) 930-0035.

# FLORIDA DESIGNATION OF HEALTH CARE SURROGATE

Name: \_\_\_\_\_  
                        Last  First  Middle Initial

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

If my surrogate is unwilling or unable to perform his duties, I wish to designate as my alternate surrogate:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize admission to or transfer from a health care facility.

Additional Instructions (Optional):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I further affirm that this designation is not being made a condition of treatment or admission to a health care facility, I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Principal Signature

Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Witnesses

1. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

***At least one witness must not be a husband or wife or a blood relative of the principal.***

# FLORIDA LIVING WILL DECLARATION

Declaration, made this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

I, \_\_\_\_\_  
willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and do hereby declare that, if at any time I am mentally or physically incapacitated and:

\_\_\_\_\_ (initial) I have a terminal condition  
or \_\_\_\_\_ (initial) I have an end stage condition  
or \_\_\_\_\_ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do \_\_\_\_\_, I do not \_\_\_\_\_ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City and State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

**Additional Instructions (Optional):**

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**Signed:** \_\_\_\_\_

Witness: \_\_\_\_\_ Witness: \_\_\_\_\_

Street Address: \_\_\_\_\_ Street Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

*At least one witness must not be a husband or wife or blood relative of the principal.*

# Health Care District of Palm Beach County

GRIEVANCE FORM	
Name: _____	ID # _____
Date: _____	
Patient Name: _____ <small>(If different from member)</small>	Relationship to member: _____
Phone (Home): _____	Phone (Business): _____
Address: _____	
City: _____	State: _____ Zip Code: _____
Location of service: _____	
Physician Involved _____	
Description of Grievance: _____	
What date was service provided? _____ By whom? (Physician/hospital) _____	
If your Grievance involves the denial of a claim payment, have you been paid for this care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how much? _____ Whom did you pay? _____	
Can you provide proof of payment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If your Grievance is a denial of service, have you received this service somewhere else? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, where? _____ When? _____	
By whom? _____ If no, what is the service needed? _____	
Other comments _____	
Signature _____ Date: _____	
_____ <small>(Print Name)</small>	_____ <small>(Relationship to patient)</small>
Grievance Coordinator: _____	Case # _____

**RETURN TO: RISK MANAGEMENT**  
**324 Datura Street, Suite 401**  
**West Palm Beach, FL 33401-5432**  
**Telephone: (866)-930-7750      FAX: (561)-833-9786**

# MEMBERS RIGHTS AND RESPONSIBILITIES

The Health Care District is committed to quality health care for all District members. Each member of the District, has been granted certain rights and responsibilities under this program regarding the provision of services and the management of their health care. A summary of the Rights and Responsibilities are listed below:

## MEMBER RIGHTS

- Right of prompt access to quality health care services;
- Right to receive considerate and respectful care;
- Right to expect convenient office hours and reasonable waiting times, both for an appointment and at a physician's office;
- Right to understand their health problem and treatment options that are available, as well as the risks that are involved;
- Right to be informed of any special diagnostic and treatment procedures including surgery, and the right to refuse treatment to the extent permitted by law; however, unreasonable refusal of medical treatment may lead to disenrollment or denial of payment of services by the District;
- Right to expect that all medical information concerning one's health status will only be released by receipt of written permission, except in cases where:
  - Clinical information is required by other health care professionals for a member's care;
  - District requires information to substantiate payment to a provider for utilization of services and/or quality of care;
  - Provider is legally obligated to release information.
- Right to choose their own primary care physician and to change their primary care physician upon change of residence or upon each new eligibility period;
- Right to express problems they may have with their PCP, and to receive fair and timely consideration for their concerns;
- Right to be treated in a fair and equitable manner and not to be discriminated against because of age, sex, place of residence, income, religion, national origin, or illness;
- Right to expect an efficient and effective health care delivery system that is responsive to their health care needs and promotes quality health care;

## MEMBER RESPONSIBILITIES

- Responsible to have all health care services provided or coordinated through their participating primary care physician, except in emergency situations;
- Responsible to notify physician's office of appointment lateness or cancellations, (a member who misses three (3) appointments within a consecutive six (6) month period may be disenrolled by the District);
- Responsible to follow District policies and procedures;
- Responsible to recognize that there are exclusions and Limitations/Exclusions to District coverage policies and that member is responsible for payment of those services;
- Responsible to follow prescribed medical treatment, (unreasonable refusal may lead to disenrollment or denial of payment of services by the District)
- Responsible to notify the District of any changes in income, address, or eligibility for other insurance coverage.

## **Health Care District Option #1 Referral Process for Nutrition Appointments**

### **I. Instructions for nutrition referrals for Diabetes- and/or Renal Insufficiency**

**Clients with type 2 diabetes, gestational diabetes or renal insufficiency – Do not Need Authorization**

1. Complete Nutrition Referral form with all relevant information.
2. Make nutrition appointment for client. Nutrition appointments can be made in West Palm Beach, Delray Beach and Belle Glade. Call the appropriate site to schedule and appointment. Please identify yourself as a Health Care District physician office and state that you need to make nutrition appointment.
  - West Palm Beach - (561) 514-5500
  - Delray Beach - (561) 274-3126
  - Belle Glade - (561) 996-1600
3. The following information is needed to make a nutrition appointment:
  - Client name
  - Client phone number
  - Date of birth
  - Social Security number
4. Fax Nutrition Referral form to Nutrition Services at (561) 840-0152 and give the client a copy of the Nutrition Referral form.

### **II. Instructions for all other nutrition referrals-Need Authorization**

1. Complete Nutrition Referral form with all relevant information.
2. Complete Authorization Request Form.
3. Make nutrition appointment for client. Nutrition appointments can be made in West Palm Beach, Delray Beach and Belle Glade. Call the appropriate site to schedule an appointment. Please identify yourself as a Health Care District physician office and state that you need to make a nutrition appointment.
  - West Palm Beach - (561) 514-5500
  - Delray Beach - (561) 274-3126
  - Belle Glade - (561) 996-1600
4. The following information is needed to make a nutrition appointment:
  - Client name
  - Client phone number
  - Date of birth
  - Social Security number
5. Fax both the Nutrition Referral form and Authorization Request Form to the Intake Department at (561) 835-8606
6. Fax the Nutrition Referral form to Nutrition Services at (561) 840-0152 and give the client a copy of the Nutritional Referral form.
7. The Health Care District will notify both the requesting physician and Nutrition Services of the decision to approve or deny reimbursement of the requested service within 72 hours.

**Clients cannot be seen without a Nutrition Referral and necessary authorization.**

Please contact Susan Grammond at (561) 840-0175 for additional information.



# HEALTH CARE DISTRICT NUTRITION REFERRAL

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Client Phone No: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Payor Source:  Health Care District Option #1

No authorization needed for the following diagnoses:

Diabetes (Type 2 or Gestational)

Renal Insufficiency

Authorization needed for the following diagnoses:

Hypertension  
High Triglycerides

High Cholesterol  
Other \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Medications: \_\_\_\_\_

Reason for Nutrition Referral/Diet Order: \_\_\_\_\_

Lab Values:                      Results/Date                      Lab Values                      Results/Date

Blood Glucose                      \_\_\_\_\_                      HDL                      \_\_\_\_\_

Cholesterol                      \_\_\_\_\_                      LDL                      \_\_\_\_\_

Triglycerides                      \_\_\_\_\_                      Glycohemoglobin (if diabetic)                      \_\_\_\_\_

Other Labs: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax #: \_\_\_\_\_

To schedule a nutrition appointment, please call the most convenient location.

1150 45<sup>th</sup> Street  
West Palm Beach  
(561) 514-5500

225 S. Congress Ave.  
Delray Beach  
(561) 274-3126

38754 Ste Road 80  
Belle Glade  
(561) 996-1600

Date of Nutrition Appointment: \_\_\_\_\_

Please fax Nutrition Referral to (561) 514-5539  
Please give copy of Nutrition Referral to client.

**HEALTH CARE DISTRICT OF PALM BEACH COUNTY**  
**CUSTOMER SERVICES DEPARTMENT**  
**(866) 930-0035 (TOLL FREE WITHIN PALM BEACH COUNTY)**  
**324 Datura Street, Suite 401, West Palm Beach FL 33401-5432**  
**Tel: (561) 659-0035 (Outside Palm Beach County) Fax: (561) 659-7701**

**PROVIDER INQUIRY FORM**

<u>Provider Name and Address</u>		<u>Person to contact in Provider's Office</u>	
<u>Date of inquiry</u>	<u>Telephone Number</u>	<u>Fax Number</u>	

<u>Member Name (Last, First, Mi.)</u>		<u>Member Number</u>	<u>Social Security No.</u>
<u>Providing Physician Name</u>	<u>Date(s) of Service</u>	<u>Procedure Code</u>	<u>Total Amount Billed</u>
<u>Nature of Inquiry (check one)</u>	<b>CLAIM STATUS</b> Please Allow 30 Days From Submission Date	<input type="checkbox"/>	<b>APPEAL STATUS</b> <input type="checkbox"/>
<u>Response (For HCD use)</u>			

<u>Member Name (Last, First, Mi.)</u>		<u>Member Number</u>	<u>Social Security No.</u>
<u>Providing Physician Name</u>	<u>Date(s) of Service</u>	<u>Procedure Code</u>	<u>Total Amount Billed</u>
<u>Nature of Inquiry (check one)</u>	<b>CLAIM STATUS</b> Please Allow 30 Days From Submission Date	<input type="checkbox"/>	<b>APPEAL STATUS</b> <input type="checkbox"/>
<u>Response (For HCD use)</u>			

<u>Member Name (Last, First, Mi.)</u>		<u>Member Number</u>	<u>Social Security No.</u>
<u>Providing Physician Name</u>	<u>Date(s) of Service</u>	<u>Procedure Code</u>	<u>Total Amount Billed</u>
<u>Nature of Inquiry (check one)</u>	<b>CLAIM STATUS</b> Please Allow 30 Days From Submission Date	<input type="checkbox"/>	<b>APPEAL STATUS</b> <input type="checkbox"/>
<u>Response (For HCD use)</u>			

# REFERRAL FORM



HEALTH CARE DISTRICT  
OF PALM BEACH COUNTY



Healthy Palm Beaches, Inc.

- OPTION 1     OPTION 3  
 OPTION 2     TRAUMA     RETRO

Personal Health Plan (PHP)

DATE: \_\_\_\_\_

REFERENCE #: \_\_\_\_\_

**\*\*CONFIDENTIAL HEALTH INFORMATION\*\***

Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient/member or under circumstances that do not require patient/member authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

TELEPHONE #: (866) 930-7722

FAX #: (561) 835-8606

**\*\*\*Prior to visit call Customer Service at (866) 930-0035 to verify eligibility\*\*\***

Mbr. Name: \_\_\_\_\_ Eligibility: \_\_\_\_\_ to: \_\_\_\_\_  
Mbr. #: \_\_\_\_\_ Phone #: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Requesting MD: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**SERVICE REQUEST:** \_\_\_\_\_

(PHP ONLY): Is referral a result of a Child Health Check-up evaluation?     Yes     No

Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Facility: \_\_\_\_\_ Appt. Date/D.O.S. \_\_\_\_\_ # Visits: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 Code(s): \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 Code(s): \_\_\_\_\_

Procedure: \_\_\_\_\_ CPT/HCPCS Code(s): \_\_\_\_\_

Procedure: \_\_\_\_\_ CPT/HCPCS Code(s): \_\_\_\_\_

Hx or Other Comments: \_\_\_\_\_

## STATUS

**\*\*\*\*INTERNAL USE ONLY BELOW THIS LINE\*\*\*\***

Dates of Service: From: \_\_\_\_\_ Thru: \_\_\_\_\_

LOS/Visits: \_\_\_\_\_  Approved     Denied    By: \_\_\_\_\_ Date: \_\_\_\_\_

Reason/Comments: \_\_\_\_\_

Faxed To: (PCP) \_\_\_\_\_ Fax #: \_\_\_\_\_

Faxed To: \_\_\_\_\_ Fax #: \_\_\_\_\_

Faxed To: \_\_\_\_\_ Fax #: \_\_\_\_\_

Submit Claims: Health Care District, P.O. Box 2886, West Palm Beach, FL 33402-2886  
Healthy Palm Beaches, Inc., P.O. Box 3045, West Palm Beach, FL 33402-3045  
Trauma, P.O. Box 0637, West Palm Beach, FL 33402-0637

This **DOES NOT GUARANTEE PAYMENT**. Payment of benefits is subject to member's eligibility on the date the service is rendered or to any other contractual provision of the plan.

\*NOTICE. This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is prohibited. If you have received this message in error, please notify us immediately and destroy the related message.

**REQUEST FOR APPEAL**

Coordinated Care Program

Trauma Program

<b>Provider Name and Address</b>	<b>Contact Name in Provider's Office</b>	<b>Telephone Number</b>	<b>Fax Number</b>
<b>Member Name (Last, First, MI)</b>	<b>Member Number</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Date of Inquiry</b>	<b>Date(s) of Service</b>		

I do not agree with the determination you made on my claim as described on my Remittance Advice dated: \_\_\_\_\_  
(Please enclose a copy of the Remittance Advice and additional documentation.)

**Reason:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Response (For Plan Use Only)**

- Claim paid on \_\_\_\_\_ date
- Appeal Approved – Claim Reversed to Pay
- Appeal Denied (reason(s) checked below)
  - Appeal filing period >30 days from denial date
  - Claim received >180 days from DOS
  - Appealed claim for DOS >360 days
  - Following Medical Director's review
  - Member not eligible for benefits on DOS
  - Service not covered in \_\_\_\_\_ benefit plan
  - Previously appealed/Decision Final
  - Other insurance coverage
  - No medical documentation submitted
  - No intensity of service\*
  - No severity of service\*

\*Applicable to Coordinated Care Program **ONLY**

Other: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# Health Care District of Palm Beach County

**CLAIMS DEPARTMENT**  
324 Datura Street, Suite 401, West Palm Beach, FL 33401-5432  
FAX: (561) 659-7701  
REQUEST FOR REVIEW

## ACKNOWLEDGEMENT NOTICE

Provider Name: \_\_\_\_\_  
Contact  
Name: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

DEAR PROVIDER, WE ARE IN RECEIPT OF YOUR REQUEST FOR  
REVIEW FOR THE CLAIMS AND CLAIMANTS LISTED BELOW.  
WE WILL EXPEDITE YOUR REQUEST AS QUICKLY AS  
POSSIBLE. PLEASE ALLOW 30 DAYS BEFORE FOLLOW-UP FOR  
STATUS. THANK YOU.

<b>MEMBER NAME</b>	<b>CLAIM NUMBER</b>	<b>DATE OF SERVICE</b>	<b>TOTAL BILLED</b>

---

SIGNATURE

DATE



# MD REQUEST FOR NON-FORMULARY MEDICALLY NECESSARY MEDICATION



**FAX COMPLETED FORMS TO: 561-733-6663**

Important: Use one request form per drug  
Incomplete forms will not be processed

**Requesting Provider Name:** \_\_\_\_\_ **Provider Phone #:** \_\_\_\_\_  
**Name of Patient/Member:** \_\_\_\_\_ **Provider Fax #:** \_\_\_\_\_  
**Patient/Member ID#:** \_\_\_\_\_ **Patient DOB:** \_\_\_\_\_  
**Diagnosis Name (do not use ICD codes):** \_\_\_\_\_  
**Drug Name:** \_\_\_\_\_ **Drug Strength:** \_\_\_\_\_  
**Directions:** \_\_\_\_\_ **Quantity:** \_\_\_\_\_ **Refills:** \_\_\_\_\_  
**Patient's Weight (Synagis RXs only):** \_\_\_\_\_ **Trauma Patient: YES NO**

**Please describe/explain why patient cannot utilize a formulary medication. Please include a list of medications that the patient has previously tried, including doses, durations, and reasons for discontinuation:**

\_\_\_\_\_

\_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Retail pharmacy name and phone # that the patient utilizes:** \_\_\_\_\_

**HCD pharmacy name and phone # that the patient utilizes (please circle one site below):**

	<b>West Palm</b>	<b>Riviera Beach</b>	<b>Lantana</b>	<b>Delray Beach</b>	<b>Belle Glade</b>
<b>Phone #:</b>	561-209-2577	561-209-2579	561-209-2575	561-209-2570	561-209-2580
<b>Fax #:</b>	561-514-5545	561-882-0317	561-586-8690	561-265-2593	561-992-6278

**\*\*Important: IF REQUEST FOR A NON-FORMULARY MEDICATION IS APPROVED, THE APPROVAL FORM WILL BE FORWARDED TO MAXCARE FOR CLAIM PROCESSING. MAXCARE WILL NOTIFY THE DISPENSING PHARMACY SO THE STAFF CAN CONTACT THE PATIENT FOR RX PICK UP. IF THE REQUEST IS NOT APPROVED, THIS FORM WILL BE FAXED BACK TO THE PRESCRIBER'S OFFICE FOR PROPER FOLLOW UP. THE APPROVAL FOR THIS REQUEST IS CONTINGENT UPON MEMBER ACTIVE ELIGIBILITY STATUS/CRITERIA AND SPECIFIC PLAN COVERAGE AND LIMITATIONS.**

**PHARMACY SERVICES USE ONLY:**

<p><b><u>ADDITIONAL ACTION REQUIRED:</u></b></p> <p><input type="checkbox"/> PLEASE COMPLETE FORM</p> <p><input type="checkbox"/> PLEASE SUBMIT CURRENT PERTINENT LABWORK</p> <p><input type="checkbox"/> PLEASE PROVIDE CULTURE/SENSITIVITY INDICATING _____(+)</p> <p><input type="checkbox"/> PLEASE PROVIDE ADDITIONAL OFFICE NOTES/PATIENT CHART</p> <p><input type="checkbox"/> ILLEGIBLE—PLEASE CLARIFY HANDWRITING</p> <p><input type="checkbox"/> PLEASE CLARIFY _____</p> <p><input type="checkbox"/> OTHER _____</p>	<p><b>REQUEST APPROVED:</b> _____</p> <p><b>DATE:</b> _____</p> <p><input type="checkbox"/> APPROVED FOR _____ + _____ REFILLS AT HCD / RETAIL PHARMACY SITES</p> <p><input type="checkbox"/> PLEASE NOTE: _____</p>
---	--

<p><b>REQUEST DENIED:</b> _____ <b>DATE:</b> _____</p> <p><input type="checkbox"/> PLEASE CONSIDER UTILIZING HCD FORMULARY MEDICATION (i.e. _____)</p> <p><input type="checkbox"/> DRUG EXCLUSION: PLEASE CONSIDER CONTACTING PATIENT ASSISTANCE PROG AT _____</p> <p><input type="checkbox"/> INAPPROPRIATE DOSING AND/OR DIAGNOSIS</p> <p><input type="checkbox"/> DRUG EXCLUSION: OVER-THE-COUNTER MEDICATION</p> <p><input type="checkbox"/> OTHER _____</p>
--

**Confidentiality Statement**

**This facsimile transmission and any accompanying documents contain information belonging to the sender which may be confidential and legally privileged. This information is intended ONLY for the use of the individual or entity to whom this facsimile transmission was sent as indicated above. If you are not the intended recipient, any disclosure, copying, distribution or action taken in reliance on the contents of the information contained in this facsimile transmission is strictly prohibited. If you have received this transmission in error, please call us to arrange for the returns of the documents. Thank you.**

## Health Care District of Palm Beach County RISK MANAGEMENT INCIDENT REPORT

This form is to be used for an occurrence with actual or potential injury to members.

### DO NOT FILE IN MEDICAL RECORD

<b>CONFIDENTIAL DO NOT COPY</b>	<b>INCIDENT REPORT FORM</b>	<b>CONFIDENTIAL DO NOT COPY</b>
Date of incident:	Time of incident:	Location of incident:
<b>Person Affected</b>		
Name: (Last, First, MI)	Address: City, State, Zip: Phone:	Male    Female    Age:  Date of birth:
Patient Medical Record Number:	Diagnosis:	Scheduled procedure:
Was the person affected:		
Patient <input type="checkbox"/> Visitor <input type="checkbox"/> Employee <input type="checkbox"/> Medical Staff <input type="checkbox"/> Contract Staff <input type="checkbox"/> Other <input type="checkbox"/>		
HCD Number:	SSN:	
<b>Patient Status at time of the incident:</b>		
<input type="checkbox"/> Confused	<input type="checkbox"/> Not applicable	<b>Vital Signs at the time of the incident:</b> BP:                      Temp: P:                         R: Time:                    Taken by:
<input type="checkbox"/> Agitated	<input type="checkbox"/> Disoriented	
<input type="checkbox"/> Sedated	<input type="checkbox"/> Other	
<input type="checkbox"/> Uncooperative		
<b>Notification</b>		
Physician Name:	Family Member:	Risk Manager:
Date and time:	Date and time:	Date and time:
<b>Describe the incident:</b> (include outcome, ICD-9 code of injury, if applicable)		
Medication Error    Adverse effect <input type="checkbox"/> Yes <input type="checkbox"/> No    Drug		
Allergic Reaction    Adverse effect <input type="checkbox"/> Yes <input type="checkbox"/> No    Drug		
Equipment related:		
Type of equipment _____	ID # _____	
Taken out of service? <input type="checkbox"/> Yes <input type="checkbox"/> No	Item sent for repair? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No    Disposition:		
<b>Witness</b>		
Name: (Last, First, MI)	Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	If other than employee, address and phone number;
Signature of reporting person (include title, date, and phone #)		
Reviewed by Risk Manager _____ on _____		

Upon completion, mail this to: **Health Care District of Palm Beach County**  
**324 Datura Street, Suite 401**  
**W. Palm Beach, FL 33401-5432**  
**Confidential to Risk Manager**

Confidential

DO NOT COPY

Confidential



## **SECTION 11 - APPENDIX**

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### **INDEX OF APPENDIX**

**DRUG REPLACEMENT PROGRAM**

**PRIMARY CARE PHYSICIAN GUIDELINES**

**QUALITY INDICATORS**

# **DRUG REPLACEMENT PROGRAM**



# HEALTH CARE DISTRICT CHEMOTHERAPY SERVICES

## OFFICE VISITS:

- ◆ Require no authorizations
- ◆ Flu Shots & Pneumovax must be obtained at the Health Department

## LAB SERVICES

- ◆ Urgent or STAT lab in office
- ◆ Routine laboratory services must be provided by a participating lab:
  - Quest Diagnostics
  - Health Department Lab
  - Participating Hospital Lab

## INJECTABLE (NON-CHEMO) MEDICATIONS:

- ◆ The following medications **must** be obtained from one of our Health Care District pharmacies.
  - Neupogen – may be a replacement medication
  - Procrit
- ◆ If you are requesting Neupogen as a replacement medication, the patient must print and sign their name on the Patient Authorization Statement. If the patient is represented by a legal guardian, please have representative print and sign their name in the appropriate place and witnessed. The Patient Authorization Statement must be forwarded with the prescription to the pharmacy.
- ◆ Our pharmacies are located at one of the County Health Department sites. The following process should be utilized:
  1. Provider writes Rx for patient.
  2. Patient should go to a HCD pharmacy for pick up of medication.
  3. Patients may be given up to a 1-week supply.
- ◆ All other injectable medications will be reimbursed per provider contract.

## REPLACEMENT CHEMOTHERAPY DRUGS – INFUSED:

- ◆ Chemotherapy may be obtained in one of the following manners:
  - HCD replacement of chemotherapy medication to physician office.
  - Patient obtains replacement chemotherapy medication directly from HCD pharmacy.



# HEALTH CARE DISTRICT CHEMOTHERAPY SERVICES

## CHEMOTHERAPY DELIVERED TO PHYSICIAN OFFICE:

1. Provider will complete "Infused Chemotherapy / Safety Net® Program Form."
2. "Infused Chemotherapy / Safety Net® Program Form" and copy of prescription will be faxed to HCD pharmacy.
3. HCD pharmacy will need 72 hours notice to ensure time to order and receive chemotherapy.
4. HCD pharmacy will arrange to have chemotherapy delivered directly to physician office.
5. Patient can receive up to a 1-week supply to be delivered to physician office.



## HEALTH CARE DISTRICT CHEMOTHERAPY SERVICES

### Rx PRESENTED TO HCD PHARMACY BY PATIENT:

1. Provider writes Rx for replacement chemotherapy.
2. Patient presents Rx to HCD pharmacy.
3. Patient can receive up to a 1-week supply of meds to take to provider office.

### CHEMOTHERAPY ORAL:

- ◆ Oral chemotherapy must be obtained from one of our HCD pharmacies, which are located at one of the County Health Department.
  1. Provider office writes Rx for oral chemotherapy.
  2. Patient presents Rx to HCD pharmacy.
  3. Patient can receive up to a 30-day supply.

### SALINE/MEDICAL SUPPLIES:

- ◆ Will be reimbursed per provider contract.



# AUTHORIZATION PROCESS

## AUTHORIZATION #:

- ◆ Intake Line: (866) 930-7722
- ◆ Fax: (561) 835-8606

## SERVICES REQUIRING AUTHORIZATIONS:

- ◆ All inpatient hospital admissions
- ◆ All inpatient rehab (physical medicine) admissions
- ◆ Dialysis
- ◆ Durable Medical Equipment (DME)
- ◆ Home Health Services
- ◆ Home Infusion Services
- ◆ Hyperbaric Oxygen Therapy (outpatient)
- ◆ Orthotics / Prosthetics
- ◆ Non-emergent Transportation
- ◆ Penicillin Allergy Testing
- ◆ Pet Scans
- ◆ Referrals to out of network providers
- ◆ Therapy (outpatient, PT/OT/ST/RT)
- ◆ Specialty Physician Office Visits (except dermatology, endocrinology, podiatry, OB/GYN and hematology/oncology) for covered services by participating providers
- ◆ Wound Care

## AUTHORIZATION PROCEDURE:

- ◆ Fax a completed Referral Form to (561) 835-8606  
or
- ◆ Call the Intake Department at (866) 930-7722 for an authorization.
- ◆ Please provide request at least 72 hours prior to the date of service for all routine requests.
- ◆ **URGENT** requests may be called into the Intake Department.
- ◆ Once the request for authorization is received and reviewed, a response will be faxed within 72 hours to the requestor with the decision to approve or deny.



## **ADVANCE REGISTERED NURSE PRACTITIONER (ARNP)**

- ◆ Requirements for participation with the District:
  - ◆ Must be affiliated with a network provider
  - ◆ Must complete Provider Application and complete the credentialing process (please refer to the Provider Handbook, Section 5, Provider Guidelines)
  - ◆ Must sign a Provider Agreement
- ◆ Reimbursement is 85% (ARNP) x 80% of the Medicare Fee Schedule for services provided.

*\*Please note the credentialing process may take up to (180) days for completion.*



***PHARMACY LOCATIONS***  
**(Located in the following Public Health Units)**

<b><u>Pharmacy &amp; Address</u></b>	<b><u>Phone/Fax</u></b>
<b>Belle Glade HCD Pharmacy-06 38754 State Road 80 Belle Glade, FL 33430</b>	<b>Ph: (561) 209-2580 Fax: (561) 992-6278</b>
<b>Delray Beach HCD Pharmacy-03 225 South Congress Avenue Delray Beach, FL 33444</b>	<b>Ph: (561) 209-2570 Fax: (561) 265-2593</b>
<b>Lantana HCD Pharmacy-04 1250 Southwinds Dr. Lantana, FL 33462</b>	<b>Ph: (561) 209-2575 Fax: (561) 586-8690</b>
<b>Riviera Beach HCD Pharmacy-05 7289 Garden Road, Suite 101 Riviera Beach, FL 33404</b>	<b>Ph: (561) 209-2579 Fax: (561) 882-0317</b>
<b>West Palm Beach HCD Pharmacy-02 1150 – 45<sup>th</sup> Street West Palm Beach, FL 33407</b>	<b>Ph: (561) 209-2577 Fax: (561) 514-5545</b>





# ADMINISTRATIVE CONTACT LIST

## PROVIDER SERVICES:

- ◆ Phone: (866) 930-1002  
(561) 659-1002
- ◆ Fax: (561) 833-9469

## AUTHORIZATIONS:

- ◆ Intake Line: (866) 930-7722  
(561) 659-7722
- ◆ Fax: (561) 835-8606

## CUSTOMER SERVICES:

- ◆ Main Number: (866) 930-0035  
(561) 659-0035
- ◆ Fax: (561) 659-7701

## CLAIMS DEPARTMENT:

- ◆ All claims should be submitted to:

Health Care District  
PO Box 2886  
West Palm Beach, FL 33402

## WEBSITE:

- ◆ [www.hcdpbc.org](http://www.hcdpbc.org) (complete Provider Handbook is available on the website)



## ELIGIBILITY OFFICES

<p><b>BELLE GLADE</b> 1500 B NW Avenue L Belle Glade, FL 33430 (561) 992-4255 and (561) 992-4253 Fax: (561) 992-5053 Supervisor: Ronni Lapides</p>	<p><b>DELRAY BEACH</b> 225 South Congress Avenue Delray Beach, FL 33444 (561) 274-3133 Fax: (561) 802-3963 Supervisor: Eric Kelly</p>
<p><b>LANTANA</b> 1250 Southwinds Drive Lantana, FL 33463 (561) 547-6842 Fax: (561) 802-3964 Supervisor: Ernande Jean-Paul</p>	<p><b>WEST PALM BEACH</b> 1150 45<sup>th</sup> Street (561) 514-5390, (561) 514-5386 and (561) 514-5388 Fax: (561) 802-3961 Supervisor: Altamese Pla</p>



# INFUSED CHEMOTHERAPY/ SAFETY NET® PROGRAM FORM

Date:		Member HCD #	
Member Name:		Member DOB:	

Medication to be replaced:

NAME OF MEDICATION	DOSAGE FORM / STRENGTH	QTY.

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

To be delivered to the following address:

\_\_\_\_\_

\_\_\_\_\_

***Please fax replacement form along with the prescription to the closest HCD Pharmacy.***

***Please circle the appropriate pharmacy:***

***Belle Glade Pharmacy***  
***Fax: (561) 992-6278***

***Delray Beach Pharmacy***  
***Fax: (561) 265-2593***

***Riviera Beach Pharmacy***  
***Fax: (561) 845-1759***

## PATIENT AUTHORIZATION STATEMENT

My doctor has prescribed Amgen products for me, and I would like to receive the drug free of charge through the SAFETY NET® Program. In order to participate, I hereby certify that the financial/insurance information listed on page 1 is accurate.

I understand that, in order to determine my eligibility to participate in the SAFETY NET® Program, Amgen needs information about the type and date of my medical diagnosis and treatment, my family income, and my health insurance. I agree to permit information about me to be given to Amgen to support my initial application, which may include a verification of coverage with my insurance company, and to update my records to show that I continue to qualify for the SAFETY NET® Program.

This authorization expires the later of one year after the date of execution or one year after the last date I receive product under this program. I understand that this information identifying me will not be used for any purpose other than for the SAFETY NET® Program unless

- I give written authorization, or
- It is required by the government, or
- Amgen first removes my name and any other identifying information.

\_\_\_\_\_  
*Type or print name of patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Type or print name of legal representative (if applicable)*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_  
*Signature of patient or legal representative*

## SPONSOR CERTIFICATION STATEMENT

I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the SAFETY NET® Program of any changes that I become aware of, which could affect the patient's eligibility status.

\_\_\_\_\_  
*Sponsor Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Phone Number*

**Fax completed forms to:**

**Health Care District  
Pharmacy Distribution Center**

**Fax: (561) 832-4016**

## Instructions

1-880-272-9376

The SAFETY NET® Program for Amgen product replaces product dispensed to eligible medically needy patients who qualify for the program. Patients must meet certain insurance and financial criteria. No cash payments are involved. A hospital, physician, home healthcare company, or community pharmacy may become a sponsor and must apply to the program on behalf of the patients.

If you prefer to pre-approve a patient over the telephone, please call the SAFETY NET® Program for Amgen products at 800-272-9376. You will speak with a specialist who will determine if your patient is eligible for the program and who will assist you with completing Forms A and B. Please be prepared with the patient's name, Social Security number, annual family income, and insurance information. You will also need to first obtain the patient's authorization to disclose confidential patient-identifiable information (including, but not limited to, name, Social Security number, address, ZIP code, policy number or employer), for purposes of seeking reimbursement assistance or enrollment into the SAFETY NET® Program. Eligible patients will be enrolled once the completed forms (Form A and Form B) are signed by the provider and patient and returned to the program by fax or mail.

If you prefer to complete your own applications, please follow the three steps listed below.

- Step 1: A hospital, physician, home healthcare company, or community pharmacy may become a sponsor. To become a sponsor, the provider must sign a Sponsor Form (Form A), which confirms that the provider understands the program's terms. Form A needs to be submitted only once, regardless of the number of patients enrolled in the program. Additional documentation may be required.
- Step 2: The sponsor submits a Patient Enrollment Form (Form B) for each patient, which is used to determine patient eligibility. **The patient's signature indicating authorization to release confidential patient-identifiable information is required on this form.** The program specialist will contact the sponsor annually to confirm that the patient continues to meet eligibility criteria. Once a patient's 12-month enrollment period ends, a new Patient Enrollment Form (Form B) will be required for re-enrollment in the program. Additional documentation may be required.
- Step 3: The sponsor submits the Amgen Product Dosage Tracking Form (Form C) at the end of each month or quarter for each enrolled patient. This form documents the amount of Amgen products to be replaced and must be signed by a physician or accompanied by a copy of the signed prescription. The provider will receive vials approximately 30 days after Form C is received by the program.

Amgen reserves the right to approve or deny any SAFETY NET® Program application or to modify or discontinue the program with respect to any patient or provider, in part or in its entirety, at any time. Amgen reserves the right to make an independent determination of medical indigence in all cases.

Form B

1-880-272-9376

Patient Enrollment Form

Instructions: For assistance in completing this application, please call 1-800-272-9376. Sponsors must contact the hotline or submit this form to begin enrollment of a patient in the SAFETY NET® Program for Amgen products. Information supplied on this form will be strictly confidential.

1. Sponsor Information

Sponsor Name \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Sponsor Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax \_\_\_\_\_  
SAFETY NET® Program Sponsor Number \_\_\_\_\_

2. Patient Information

Patient Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

Aranesp® (darbepoetin alfa)       Neuleast™ (pegfilgrastim)       NEUPOGEN®  
(Filgrastim)

Diagnosis \_\_\_\_\_ Estimated Dose/Day \_\_\_\_\_

Is this being paid under a case rate?      \_\_\_ Yes      \_\_\_ No

EPOGEN® (Epoetin alfa) Is the patient currently on dialysis?      \_\_\_ Yes      \_\_\_ No

First Date of Dialysis \_\_\_\_\_ Estimated EPOGEN® Dose/Week \_\_\_\_\_

Physician Name \_\_\_\_\_

Physician Address \_\_\_\_\_

3. Financial/Insurance Information

- Income: Patient's adjusted annual gross family income

\_\_\_\_\_

- Insurance: Please check all insurers from which this patient qualifies for benefits:

<u>Insurer</u>	<u>Status</u>				<u>Date</u>
Medicare	___ Yes	___ No	___ Pending	___ Denied	Effective _____
Medicaid	___ Yes	___ No	___ Pending	___ Denied	Effective _____
Commercial	___ Yes	___ No	___ Pending	___ Denied	Effective _____
VA/DoD	___ Yes	___ No	___ Pending	___ Denied	Effective _____
Managed Care Plan	___ Yes	___ No	___ Pending	___ Denied	Effective _____
Other Health Ins.	___ Yes	___ No	___ Pending	___ Denied	Effective _____

Name of Health Insurer \_\_\_\_\_

**AMGEN®**

*Form B: page 1 of 2 (over)*

**4. Patient Authorization Statement**

My doctor has prescribed Amgen products for me, and I would like to receive the drug free of charge through the SAFETY NET® Program. In order to participate, I hereby certify that the financial/insurance information listed on page 1 is accurate.

I understand that, in order to determine my eligibility to participate in the SAFETY NET® Program, Amgen needs information about the type and date of my medical diagnosis and treatment, my family income, and my health insurance. I agree to permit information about me to be given to Amgen to support my initial application, which may include a verification of coverage with my insurance company, and to update my records to show that I understand this information identifying me will not be used for any purpose other than for the SAFETY NET® Program unless:

- I give written authorization, or
- It is required by the government, or
- Amgen first removes my name and any other identifying information

\_\_\_\_\_  
*Type or print name of patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Type or print name of legal representative (if applicable)*

\_\_\_\_\_  
*Witness signature*

\_\_\_\_\_  
*Signature of patient or legal representative*

**5. Sponsor Certification Statement**

I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the SAFETY NET® Program of any changes that I become aware of, which could affect the patient's eligibility status.

Sponsor Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Phone Number \_\_\_\_\_

Send completed forms to:

SAFETY NET®  
PO Box 13185  
La Jolla, CA 92039-3185  
Tel: 800-272-9376  
Fax: 888-508-8090

*Form B; page 2 of 2 Revised 2-02*

**AMGEN®**  
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Form C 1-880-272-9376  
Amgen Product Dosage Tracking Form

Instructions: To receive replacement Amgen product within 30 days, sponsors should submit this form by mail at the end of each month or treatment cycle. **In order to be processed, the form must be signed by a physician.**

1. Sponsor Information

Sponsor Name \_\_\_\_\_

Contact Person \_\_\_\_\_

Sponsor Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

2. Certification Statement

I certify that the Amgen product reported on this form, for which I am requesting free replacement, was furnished free of charge to a SAFETY NET® Program patient and was purchased by me or my institution or provided free of charge by the SAFETY NET® Program. In addition, I represent that the information contained in this form is complete and accurate to the best of my knowledge and agree to notify the SAFETY NET® Program of any changes I become aware of which could affect the eligibility of this patient.

3. Amgen Product Utilization

Patient Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

**Aranesp®** (darbepoetin alfa) Long Acting Procrit

Dates of administration: Start \_\_\_\_\_ End \_\_\_\_\_ Dose per administration \_\_\_\_\_

Total number of vials dispensed during period:

25 mcg/mL \_\_\_\_\_ 40 mcg/mL \_\_\_\_\_ 60 mcg/mL \_\_\_\_\_

100 mcg/mL \_\_\_\_\_ 150 mcg/mL \_\_\_\_\_ 200 mcg/mL \_\_\_\_\_ 300 mcg/mL \_\_\_\_\_

**EPOGEN®** (Epoetin alfa)

Dates of administration: Start \_\_\_\_\_ End \_\_\_\_\_

Total EPOGEN® units dosed during period \_\_\_\_\_ Number of doses \_\_\_\_\_

**Neulasta™** (pegfilgrastim) Long Acting Neupogen

Dates of administration: Start \_\_\_\_\_ End \_\_\_\_\_ Dose per administration \_\_\_\_\_

Total number of prefilled syringes dispensed during period:

6 mg \_\_\_\_\_

**NEUPOGEN®** (Filgrastim)

Dates of administration: Start \_\_\_\_\_ End \_\_\_\_\_ Dose per administration \_\_\_\_\_

Total number of vials dispensed during period:

0.5 mL \_\_\_\_\_ 0.8 mL \_\_\_\_\_

Send completed forms to:

SAFETY NET® Program, PO Box 13185, LA Jolla, CA 92039-3185

Tel: 800-272-9376 Fax: 888-508-8090

AMGEN®

# **PRIMARY CARE PHYSICIAN GUIDELINES**

## PRIMARY CARE PHYSICIAN GUIDELINES

This section presents Primary Care Management Guidelines adopted by the Health Care District of Palm Beach County. These guidelines are based on Milliman and Robertson guidelines for Primary Care Management and have been modified to meet the standards of the Health Care District of Palm Beach County. The primary care physician shall provide all services, which can be provided appropriately within his or her skills. When additional knowledge or skills are required, the Primary Care Physician is responsible to make an appropriate referral to a specialist for services.

### *Allergy*

Primary care physicians shall be responsible for the following:

1. Complete a thorough allergy history and make aggressive use of environmental controls before any allergy referral.
2. Treat all seasonal allergies whose symptoms do not last more than six weeks per year or whose symptoms occur in two seasons but for less than six weeks each time. Treat the patients with antihistamines and decongestants. Use steroids in brief bursts if effective and tolerated.
3. Treat chronic rhinitis and sinusitis aggressively with at least three sequential medication programs including antihistamines, decongestants and nasal sprays including steroids. Refer to an allergist if the problem is unresponsive to the above treatment and if an allergic cause is indicated by IGE or nasal eosinophils. Refer to otolaryngologist only if mechanical obstruction (e.g., adenoids, and tonsils) is obvious.
4. Treat hives aggressively for 6 to 12 weeks seeking their cause by thorough history, examination and laboratory tests, and removing cause as identified, or using antihistamines, epinephrine, systemic steroids and local measures. Refer if urticaria becomes chronic (over 6 to 12 weeks). Send laboratory work to consultant including CBC, ESR, urine, stools for ova and parasites, HBAG, strep culture, mono tests, ANA, VDRL, T4.
5. Refer to allergist for systemic reaction to insect bites or stings.
6. Classify asthma on the basis of history, examination, chest x-ray, CBC, IGE as:
  - a) associated with bronchopulmonary disease,
  - b) exercise induced,
  - c) occupational,
  - d) idiopathic (intrinsic),
  - e) immunologic (extrinsic),
  - f) mixed, or
  - g) cardiac.
7. Treat asthma when active with or without co-existing infection with:

- a) oral beta-agonists,
  - b) inhaled beta-agonists or steroids,
  - c) oral steroids,
  - d) oral theophylline,
  - e) antibiotics when appropriate,
  - f) cromolyn or nedocromil for maintenance prevention.
8. Provide education to the patient about environmental triggers and environmental controls, including the avoidance of smoking. Teach and monitor Home Peak Flow-Rate Measurements.
  9. Consider consultation if hospitalization has become necessary and obtain consultation if severe respiratory failure has occurred.
  10. For outpatients, consider consultation if the patient has become steroid dependent.

### *Cardiology*

Primary care physician shall be responsible for the following:

1. Evaluate chest pain, murmurs and palpitations, and recognize significant heart disease by history, examination, electrocardiogram, echocardiogram and stress testing including stress electrocardiogram, echocardiogram, nuclear scan or chest x-ray.
2. Evaluate and treat coronary risk factors including smoking, hyperlipidemia, diabetes and hypertension.
3. Treat hypertension, congestive heart failure, stable angina and non life-threatening arrhythmia.
4. Treat angina medically with nitrates, beta-blockers, calcium channel blockers and other medication as appropriate. Evaluate non-invasively those who may need catheterization.
5. Determine whether syncope is cardiac, i.e. valvular or arrhythmic, by history, examination, electrocardiogram, ambulatory monitoring and echocardiogram.
6. Diagnose and hospitalize patients with acute myocardial infarctions. Manage their inpatient course, discharge and follow-up care. Obtain consultation for candidates for thrombolysis, stress testing, catheterization, angioplasty, or surgery and for patients with life-threatening arrhythmia, or hemodynamic complications requiring invasive monitoring.
7. Consult for:
  - a) Unstable angina post-MI,
  - b) Post subendocardial MI with or without angina,
  - c) Angina despite maximal medical therapy with maximally tolerated doses of nitrates, beta-blockers and calcium channel blockers,
  - d) Intractable heart failure and arrhythmia,
  - e) Pericardial effusion,

- f) Congenital or valvular disease. Consult only for diagnosis, non-invasive studies and to define appropriate follow-up.

### *Dermatology*

Primary care physician shall be responsible for the following:

1. Treat painful or disabling warts with topical suspensions, electrocautery, or liquid nitrogen. Refer if the above treatment has been unsuccessful in symptomatic or functionally impaired patients.
2. Diagnose common rashes and treat them with appropriate protocols. Included would be:
  - a) Contact dermatitis,
  - b) Dermatophytosis,
  - c) Herpes genitalis,
  - d) Herpes zoster,
  - e) Impetigo,
  - f) Pediculosis,
  - g) Pityriasis rosea,
  - h) Psoriasis,
  - i) Scabies,
  - j) Seborrheic dermatitis,
  - k) Tinea versicolor.
3. Identify suspicious moles. If a suspicious lesion suggests the possibility of melanoma, refer the patient to a dermatologist trained in wide excisional surgery or a plastic surgeon.
4. Refer basal or squamous cell carcinomas to dermatologists except those on the eyelids or face, which may be referred to a facial plastic surgeon.
5. If trained, the primary care physician may do biopsies of suspicious lesions for cancer or others such as actinic keratoses.
6. Diagnose and treat common hair and nail problems and dermal injuries.
  - a) Examples of common hair problems include: fungal infections, ingrown hairs, virilizing causes of hirsutism, or alopecia, other than male pattern baldness, as a result of scarring or endocrine effects.
  - b) Examples of common nail problems include trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections and ingrown nails.
  - c) Examples of dermal injuries include: minor burns, lacerations and treatment of bites and stings.
7. Explain to patients that the removal of certain lesions is considered cosmetic by the Health Care District of Palm Beach County not covered. These lesions would include: liver spots, spider veins, wrinkles, skin tags, cysts, lipomas and flat asymptomatic warts, non-inflamed papillomas, male pattern baldness, tattoos, hereditary

hypertrichosis and non-changing pigmented lesions with the exception of dysplastic nevi, basal cell nevus syndrome and nevo-cellular nevi.

### *Endocrinology*

Primary care physicians shall be responsible for the following:

1. Manage most diabetics, including Type 1 and Type 2 patients, including patient education, supervision of home testing, medication management, regular examinations and yearly retinal examinations and renal function testing. Contract education programs may be advantageous if available.
2. Manage diabetic ketoacidosis.
3. Obtain consultation for:
  - a) Coma not rapidly reversible by glucose,
  - b) Instability in an established management program,
  - c) Complications including retinopathy and nephropathy.
4. Diagnose and treat thyroid disorders. Refer for radioiodine therapy if considered appropriate. Refer for exophthalmos if moderately severe or symptomatic.
5. Manage thyroid nodules by appropriate testing, scans and ultrasound. Refer for fine needle aspiration biopsy if indicated.
6. Refer suspected disorders of calcium metabolism, adrenal, gonadal, or pituitary dysfunction after appropriate testing has been obtained with the advice of the intended endocrine consultant.
7. Refer growth retardation only when it is clearly established as non-familial.
8. Identify and treat significant hyperlipidemia. Screening should consist of baseline total cholesterol, repeated fasting if elevated. If the repeat is still elevated, determination of triglycerides and HDL may be appropriate. Treat with diet and exercise as appropriate. Treat with medication if diet has not achieved or made substantial progress toward goal within six month. Refer if the patient had not responded to diet and medication, including two different medications, within one year.

### *Gastroenterology*

Primary care physicians shall be responsible for the following:

1. Diagnose lower abdominal pain by history, examination, CBC, urinalysis, stool for blood. Sigmoidoscopy should be performed if the stool is positive for blood or there is an altered bowel habit. Referral to surgery for suspected appendicitis or to gynecology for suspected pelvic disorder would be appropriate.
2. Diagnose and treat acute diarrhea:
  - a) Bloody-stool culture, ova and parasites, sigmoidoscopy.
  - b) Treat infectious diarrhea if identified.

- c) Non-bloody--supportive, but stool neutrophils and culture, ova and parasites if the patient is febrile or the symptoms last 72 to 96 hours.
- d) Treat infectious diarrhea if identified.
3. Treat protracted vomiting with outpatient rectal or parenteral medications. Diagnose obstruction or need for parenteral fluids by examination, x-ray and laboratory. Consider consultation if obstruction diagnosed.
4. For stools positive for blood on diet free of red meat, primary care physician should order a barium enema (air contrast) flexible sigmoidoscopy, or colonoscopy, depending on current American Cancer Society recommendations. Refer if polyps or other abnormalities are found, or if no diagnosis has been established by the examinations.
5. Diagnose and treat heartburn, upper abdominal pain, hiatal hernia and acid peptic disease.
6. Diagnose and treat functional bowel syndrome by history, examination, and laboratory, including sigmoidoscopy, barium enema, lactose tolerance, advice, symptomatic treatment.
7. Diagnose and treat jaundice by history, examination, laboratory, including hepatitis serology, ultrasound and scan if obstruction without gallstones. Refer if undiagnosed hepatocellular disease or if jaundice is complicated by fever, or intractable ascites. Refer extrahepatic bile duct obstruction.
8. Diagnose and treat ascites by history, examination, laboratory, paracentesis (if qualified), diet and diuretics. Refer if peritoneal fluid is an exudate, chylous, or intractable, or if fever persists.
9. Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids. Treatment may include diet, suppositories, and sitz baths. The primary care physician with local minor surgery should treat thrombosed external hemorrhoids. If severely symptomatic hemorrhoids are refractory to treatment, the patient may be referred for additional nonsurgical treatment.
10. Manage inflammatory bowel disease with antibiotics, steroids and supportive care, with intermittent consultation if control is not well maintained, or for colonoscopy.
11. Perform screening flexible sigmoidoscopy according to a recommended schedule by the American Cancer Society.

### ***General Surgery***

Primary care physician shall be responsible for the following:

1. Evaluate and manage small breast lumps.
2. Order screening mammography according to an approved schedule by the American Cancer Society.
3. Aspirate cysts, being sure to have careful pathological examination on bloody fluid.
4. Refer persistent cysts, lumps or suspicious mammograms. Undiagnosed masses must have excisional biopsy.

5. Refer hernias after determining risk status. Define whether incisional hernias are medically necessary or cosmetic.
6. Diagnose gall bladder disease and refer to a surgeon if significantly symptomatic. Refer to a surgeon qualified for laparoscopic cholecystectomy unless that procedure is clearly contraindicated.
7. Refer extrahepatic bile duct obstruction unless gastroenterologist will do ERCP.

### ***Gynecology***

Primary care physician shall be responsible for the following:

1. Perform routine pelvic examinations and Papanicolaou smears. These examinations should be carried out on a regular schedule as recommended by the American Cancer Society.
2. Perform laboratory testing for sexually transmitted disease for those patients with symptoms or multiple sexual partners.
3. Diagnose and treat vaginitis and sexually transmitted diseases.
4. Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes. This should include a thorough gynecological history including menstrual and sexual histories as well as symptoms. Complete pelvic examination, pregnancy testing, other laboratory studies including CBC, urinalysis, smears, cultures and ultrasound should be done. Consultation should be sought if ectopic pregnancy is present or an uncertain clinical diagnosis would benefit from another opinion or laparoscopy.
5. Diagnose vaginal bleeding by history, examination, pregnancy test, CBC and other laboratory tests. Many instances can be managed satisfactorily with hormones. If hormonal control is inadequate, the primary care physician may perform a dilatation and curettage or endometrial sample if he or she is trained to do so; if not the patient should be referred for those diagnostic services. Higher risk patients over 35 or with menometrorrhagia should be referred.
6. Diagnose and treat endometriosis with hormone therapy. If the diagnosis is uncertain, consultation may be sought and maintenance treatment provided by the primary care physician. If symptoms were refractory to drug treatment, referral for laparoscopy would be appropriate.
7. Manage premenstrual syndrome with the use of hormones, non-steroidal anti-inflammatory drugs, diuretics and other symptomatic treatment.
8. For breast diseases see General Surgery.

### ***Hematology***

Primary care physician shall be responsible for the following:

1. Diagnose and treat hypochromic anemias. If iron-deficiency is found, the primary care physician must identify the cause. If iron-deficiency is not found, consultation may be appropriate.



2. Diagnose and treat megaloblastic anemias.
3. Recognize the occurrence of hemolysis and institute appropriate testing. Diagnose congenital hemolytic anemias due to hemoglobinopathies or membrane defects. Refer spherocytosis for splenectomy. Manage sickle cell crises. Identify and remove offending chemical, pharmaceutical and physical agents. Identify underlying systemic diseases, and refer as indicated. Refer for acute hemolytic episodes, hemolyses of undiagnosed cause, and Coombs-positive acquired hemolytic anemias.
4. Recognize the anemia of chronic disease, having ruled out other major causes.
5. Refer pancytopenia for bone marrow examination, consultation and treatment of bone marrow failure or leukemia.
6. Refer for leukemia and myeloproliferative syndromes, except minimally symptomatic chronic lymphocytic leukemia.
7. Manage neutropenia over 1000 and mononucleosis. Consult for more severe neutropenia.
8. Recognize bleeding disorders and diagnose most platelet and coagulation disorders. Refer for undiagnosed conditions, suggested initial management and treat stable inactive abnormalities.

### *Neurology*

Primary care physician shall be responsible for the following:

1. Diagnose and treat all headaches, neuropathies, radiculopathies, central nervous system disorders, myofascial pain syndromes and psychophysiological diseases.
2. Diagnose and treat tension and migraine headaches, which comprise 90% of headaches in-patients under the age of 55. Treatment should include analgesics, and in difficult cases, beta-blockers or calcium channel blockers, or even antidepressants. When patients have altered mental status, focal neurological findings, or sudden onset of severe headaches with no previous history, neurological consultation and/or brain imaging may be appropriate; early neurological consultation will probably be more cost effective, since patients with normal neurological examinations have an infinitesimal likelihood of abnormal imaging.
3. Treat myofascial pain syndromes with anti-inflammatory medication and muscle relaxants. If there are questions about possible neuropathy or radiculopathy, x-rays or other tests may be indicated. If there is no improvement and an uncertain diagnosis after six to eight weeks of conservative treatment, or if there is a progressive neurological deficit, consultation would be appropriate.
4. Treat syncope and seizures. Evaluation of cardiac syncope is described in the cardiology section. If epilepsy is a consideration, the patient should have a sleep-deprived EEG ordered by the primary care physician and read by a neurologist. If a seizure disorder is diagnosed, the primary care physician should provide anticonvulsant treatment. If seizures were recurrent or refractory to treatment, neurology consultation

would be appropriate. Once the course has stabilized, follow up by the primary care physician would be appropriate.

5. Manage degenerative neurological disorders with respect to their general medical care. For confirmation of such diagnoses, neurological disorders with respect to their general medical care. For confirmation of such diagnoses, neurological consultation may be appropriate. Intermittent consultation for medication adjustment for Parkinson's disease, for example, would be appropriate but the patient's long term management should be under the primary care physician.
6. The primary care physician should manage strokes and TIA's, although brief consultation by a neurologist may be appropriate. If a classic ischemic attack is associated with a carotid lesion for which surgery would be appropriate, referral to an appropriate surgeon is indicated.

### ***Ophthalmology***

Primary care physician shall be responsible for the following:

1. Perform a thorough ophthalmologic history including symptoms and subjective visual acuity.
2. Provide common eye-related services including distant, near and color vision testing, gross visual field testing by confrontation, alternate cover testing, physical examination including direct funduscopy without dilation, extraocular muscle function evaluation and red reflex testing in pediatric patients.
3. Diagnose and treat common eye conditions including viral, bacterial and allergic conjunctivitis, blepharitis, hordeolum, chalazion, small subconjunctival hemorrhage and dacryocystitis.
4. Consultation is recommended where there is a high index of suspicion for herpes.
5. Remove corneal foreign bodies and treat corneal abrasions.
6. Referral is appropriate for metallic foreign bodies.
7. Perform tonometry.
8. Consultation is appropriate for:
  - a) sudden visual change or loss,
  - b) visual change accompanied by pain,
  - c) any eye symptom not responding to treatment,
  - d) unexplained abnormality on fundoscopic examination,
  - e) pediatric patients with disconjugate gaze, and
  - f) Lens opacification if associated with intolerable visual impairment.

### ***Orthopedics***

Primary care physician shall be responsible for the following:

1. Treat low back pain with history, exam, rest and exercises as appropriate.

2. Treat sprains, strains, pulled muscles, overuse syndromes with ice, non-steroidal anti-inflammatory drugs, analgesics, splints and stretching modalities.
3. Treat acute inflammatory conditions, such as tennis elbow, with ice, analgesics, non-steroidal anti-inflammatory drugs, splints, steroid and/or anesthetic injections and other physical modalities for up to six weeks. Refer intractable problems. Remember most patients are not professional athletes and will recover from injuries if they use RICE (rest, ice, compression, and elevation).
4. Treat chronic hip and knee problems. Conservative symptomatic care is appropriate for most patients. Referrals should be made if there is a fracture, aseptic necrosis, a locked knee, an unstable knee, and an obvious or apparent ligament tear. The primary care physician should perform arthrocentesis if indicated. If progressive disability occurs despite conservative treatment and a standing x-ray shows joint narrowing or gross destruction of the articular surface, consultation is appropriate.
5. Manage chronic pain problems if consultation has ruled out surgery.
6. Diagnose and treat common foot problems. Conservative care should include removal of ingrown nails, paring or chemical treatment of corns and/or calluses and specific changes in footwear. Bunions should be treated conservatively. Surgery should be avoided unless demanded by skin problems. Consultation should occur for deep abscess, gangrene osteomyelitis. If intractable difficulty persists despite conservative treatment, a single consultation visit may be appropriate with primary care approval of any subsequently recommended treatment plan.

### *Otolaryngology*

Primary care physician shall be responsible for the following:

1. Treat tonsillitis and streptococcal infections including scarlet fever, thoroughly. Perform and read throat cultures and/or streptococcus screens in the office.
2. Refer for consideration for tonsillectomy if there have been three documented episodes within four months or six documented episodes within one year despite adequate antibiotic treatment. Also refer if there is tonsillar obstruction or recurrent peritonsillar abscess.
3. Evaluate and treat other oropharyngeal infections such as stomatitis, herpangina, or herpes simplex.
4. Treat acute otitis media with up to three different courses of antibiotics if it is unresolved. Treat persistent effusion for up to three months if unresolved. Treat recurrent otitis media, that is three episodes within six months, with continuous low-dose prophylactic antibiotics for three to six months. Refer if acute otitis media continues toxic for 48 hours despite treatment because of consideration for tympanocentesis. Refer for persistent infection after three courses of antibiotics, for persistent effusion lasting greater than three months despite continued antibiotic treatment and for failure of prophylaxis. Refer if there is persistent hearing loss or delayed speech and articulation in children under the age of three. Evaluate with

tympanograms or audiograms. Refer if there is persistent retraction of tympanic membranes. Obtain lateral nasopharyngeal x-rays as appropriate.

5. Treat acute and chronic sinusitis with up to two courses of antibiotics for up to 20 days. Refer if infection is not responsive in 72 hours or persistent after 20 days.
6. Treat allergic or vasomotor rhinitis aggressively with antihistamines, decongestants, nasal sprays or steroids as necessary. Refer if nasal obstruction is evident despite three months of treatment.
7. Remove ear wax with hydrogen peroxide, irrigation, or curettement.
8. Treat nasal polyps with antihistamines, decongestants and nasal sprays and refer if the polyps are symptomatic and unresponsive to medical therapy.
9. Diagnose and treat acute parotitis and acute salivary gland infections with antibiotics.
10. Refer for:
  - a) Parotid masses,
  - b) Acute or persistent hearing loss not attributable to fluid or wax,
  - c) Hoarseness which persists greater than three weeks,
  - d) Hemoptysis.

### ***Pulmonary***

Primary care physician shall be responsible for the following:

1. Diagnose and treat asthma, acute bronchitis and pneumonia.
2. Diagnose and treat chronic bronchitis and chronic obstructive pulmonary disease with periodic antibiotics, inhaled or oral bronchodilators and/or steroids. Obtain the results or peak-flow rates, pulmonary function, arterial blood gas and theophylline levels as appropriate. Refer patients for respiratory failure or poor response to their regimen.
3. Manage home aerosol medications and oxygen as needed.
4. Work up possible tuberculosis or fungus infections with skin tests, sputum tests and serological tests.
5. Order chest x-rays, special views (e.g., decubitus views) and CT scans as appropriate.
6. Refer for percutaneous lung biopsies, pleural biopsies, or supraclavicular node biopsies.
7. Refer for pleural effusions not due to heart failure or acute pneumonia. Refer for unresolved pneumonia, hemoptysis, lung masses, interstitial disease, sarcoidosis, tuberculosis, and unusual infections.

### ***Rheumatology***

Primary care physician shall be responsible for the following:

1. Diagnose and treat non-articular musculoskeletal pains including, but not limited to:
  - a) overuse syndromes,
  - b) injuries and trauma,

- c) soft tissue syndromes,
  - d) bursitis or tendonitis,
  - e) With non-steroidal anti-inflammatory drugs, muscle relaxants, ice, limited physical therapy and stretching. Provide steroid injections if appropriately trained.
2. Manage osteoarthritis with analgesics, non-steroidal anti-inflammatory drugs and the judicious use of steroid injections. If there has been no response to treatment after three months, or if there is significant functional impairment despite treatment, patient should be referred.
  3. Diagnose crystal diseases by x-rays, laboratory tests, or arthrocentesis. Treat those conditions with non-steroidal anti-inflammatory drugs, colchicine, or allopurinol.
  4. Diagnose and treat rheumatoid arthritis and inflammatory arthritic diseases with all available medications and modalities, including injections and physical therapy. Consultation should be obtained when the manifestations are not controlled on the treatment program or there is a need to develop a long-range treatment plan or to consider surgery.
  5. Diagnose and treat uncomplicated collagen diseases such as lupus erythematosus, scleroderma, myositis and polymyalgia rheumatica. Consider consultation or referral depending on the extent and severity of manifestations or complications. Once treatment plans have been established, if the patient is stable, the primary care physician should follow the patient.

### *Urology/Nephrology*

Primary care physician shall be responsible for the following:

1. Diagnose and treat initial and recurrent urinary tract infections, including follow up examinations for clearing. If infections are persistent or recurrent, the physician should administer prolonged suppressive therapy. If infections are persistent or recurrent the primary care physician should look for anatomical reasons by IVP and voiding cystourethrogram.
2. Provide long term chemoprophylaxis if there have been as many as three separate infections within a twelve-month period.
3. Diagnose and treat urethritis.
4. Evaluate hematuria and refer if it is unexplained or due to a mass.
5. Evaluate incontinence and refer if obstructive lesions require treatment.
6. Diagnose and treat epididymitis and prostatitis.
7. Differentiate scrotal or peritesticular masses from testicular masses. Refer if the mass is testicular or does not transilluminate.
8. Evaluate prostatism and prostatic nodules including IVP, voiding cystourethrogram, rectal ultrasound, acid phosphatase, prostate specific antigen. Refer if the prostate is suspicious for malignancy or if obstructive symptoms lead the patient to choose surgical treatment.

9. Manage urinary stones on an outpatient basis unless oral pain control and hydration are impossible. Provide expectant care for small (4 mm or less) distal stones but refer if those do not pass in a week. Refer for larger or proximal stones for consideration of removal, stenting, or lithotripsy.
10. Evaluate renal failure by laboratory tests, ultrasound and scans. Treat renal failure by eliminating aggravating factors and dietary advice. Refer for acute renal failure, obstructive uropathy, 50% reduction in creatinine clearance, or nephrotic syndrome.
11. Refer for circumcision if there have been recurrent balanitis or foreskin problems.

### *Vascular Surgery*

Primary care physician shall be responsible for the following:

1. Diagnose abdominal aortic aneurysms by examination and ultrasound. Refer those, which are symptomatic, enlarging, or greater than 5 cm in diameter.
2. Diagnose and treat venous disease by history, examination, non-invasive studies or venography, with anticoagulation as appropriate.
3. Treat stasis ulcers.
4. Refer major arterial problems such as gangrene, ischemic ulcers, or ischemic rest pain.
5. Manage lesser arterial problems, such as intermittent claudication, transient ischemic attacks, or asymptomatic bruits with conservative measures or medical consultants such as cardiologists or neurologists.

# **QUALITY INDICATORS**

## Health Care District Quality Management Department

### Quality Indicators

#### Current Indicators

Brain or Spinal Cord Damage during a Procedure

Delay/Lack of Discharge Planning

Emergency Room Visit for Poisoning (<7 y/o)

Failure to Thrive

Low Birth Weight Newborn (<1500 grams)

Low Birth Weight Newborn (<2500 grams)

Mortality

Performance of Unnecessary/Wrong Procedure

Post-Operative Wound Infection

Readmission to Hospital within 30 Days for Similar/Same Diagnosis

Return to OR During Same Hospitalization

Unanticipated Disfigurement

Allergic Reaction to a Drug

Revised: March 8, 2004