Health First
Health Plans

Provider Manual

2022

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Section 1: Welcome to Our Provider Network

Health First Health Plans

Health First Health Plans is proud to partner with medical professionals to offer comprehensive health insurance plans to our community.

- Individual Health Maintenance Organization (HMO) and Point of Service (POS) plans — Health coverage for individuals and families, both on and off the Marketplace
- Medicare Advantage plans — An important alternative to original Medicare that offers members enhanced benefits

We're located in Brevard County

Health First is the area's only locally based Integrated Delivery Network (IDN). As part of the IDN, Health First Health Plans offers distinct advantages to its participating providers. To date, more than 4,000 providers, 23 hospitals and dozens of ancillary facilities have elected to be part of our network.

Our corporate and health plans office, executives, medical directors, managers and staff members are in Brevard County, allowing for increased accessibility and communication with our physicians and their office personnel. The largest, locally based provider network operations and engagement departments are ready to assist provider offices with claims issues, contracting questions or other concerns.

Physician involvement makes the difference

Physicians within the Health First Health Plans' network can help shape health plan activities by participating in policy committees. The Physician Advisory Committee, Credentialing Committee and Pharmacy and New Technology Committee are some of the work groups in which network physicians can become involved in decision-making. Additionally, physician leadership is evident on the Health First Health Plans' Board of Trustees as physicians represent 50% of the voting members.

Backed by the Health First family

Our health insurance products are backed by the Health First IDN, encompassing wellness and prevention care, and community-based care, including our provider network and hospitals. With the strength of the Health First family behind us, Health First Health Plans is uniquely positioned to meet the healthcare needs of our community.

Streamlined authorization

Our clinical services department is dedicated to working with you to assure high-quality healthcare for our members. With our streamlined authorization system, most covered services do not need prior authorization (PA). For those services requiring authorization, a full-time medical director

and a team of nurse case managers and clinical pharmacists are available to coordinate patient care.

The bottom line is quality of care

Health First Health Plans has an above-average medical expense ratio and below-average administrative cost when compared to other managed care organizations in Central Florida. This means that Health First Health Plans directs most of its funds toward medical care for its members. Providers benefit through competitive compensation schedules. Members benefit by having access to needed healthcare services.

Section 2: Websites and Contact Information

Provider Network and Engagement Department

Vicky Luchetti
Account Executive
Phone: 321.848.2288
Email: Joan.Goldenberg@HF.org

Tracy Yates
Account Executive
Phone: 321.914.8619
Email: Tracy.Yates@HF.org

Mahogony Roebuck
Account Executive
Phone: 704.224.3964
Email: Mahogony.Roebuck@HF.org

Tari Fazekas
Director
Phone: 321.434.4915
Email: Tarilyn.Fazekas@HF.org

Provider Network Operations Department

La'Quita Haithcoat
Operations Analyst
Phone: 321.434.4561
Email: LaQuita.Haithcoat@HF.org

Amy Crook
Provider Network Technical Specialist
Phone: 321.434.5550
Email: Amy.Crook@HF.org

Lori Haws
Operations Analyst
Phone: 321.434.5630
Email: Lori.Haws@HF.org

Shamara Greenlee – Supervisor
Provider Network Operations
Phone: 321.434.4551
Email: Shamara.Greenlee@HF.org

Sonia Ruiz
Operations Analyst
Phone: 321.434.4331
Email: Sonia.Ruiz@HF.org

Kim Nowakowski – Manager
Provider Contracting and Credentialing
Phone: 321.434.4378
Email: Kimberly.Nowakowski@HF.org

Natalie Whitehurst
Operations Analyst
Phone: 321.434.5629
Email: Natalie.Whitehurst@HF.org

Katie Fleming – Vice President
Operations and Provider Engagement
Phone: 321.434.5607
Email: Katie.Fleming@HF.org

Credentialing Department

Ada De La Nuez
Specialist
Phone: 321.434.7113
Email: Ada.DeLaNuez@HF.org

Georgian Erickson
Specialist
Phone: 321.434.4348
Email: Georgian.Erickson@HF.org

Additional Support

Customer Service
Phone: 844.522.5282
Web: myHFHP.org/4providers

Claims
Customer Service: 877-535-8278
Web: myHFHP.org/4providers

Change Health Care
Customer Service: 866.858.8938
Web:
www.changehealthcare.com/legacy/support

eviCore Healthcare
Customer Service: 877.825.7722
Portal Support: 877.825.7722
Web: www.evicore.com

Optum
Customer Service (IFP): 866.323.4077
Customer Service (MA): 877.890.6970
Web (IFP):
www.liveandworkwell.com?pin=HealthFirst
Web (MA):
www.liveandworkwell.com?pin=HealthFirstMA

Prior Authorizations
Medical: IFP
Fax: 844.965.9053
Phone (par): 844.522.5282

Medical: MA
Fax: 833.554.9046
Phone (par): 844.522.5282

Medical: Off-formulary diabetic supplies
Fax: 844.814.2259
Phone: 855.672.2755
Web: www.covermymeds.com

Medical: Supplies obtained through DME
Fax: 844.814.2259
Phone: 855.672.2755
Web: www.provider.hioscar.com

Medical Drug: IFP Non-specialty medications
Fax: 844.814.2258
Phone: 844.522.5282

Medical Drug: IFP Specialty medications
Fax: 844.814.2259
Phone: 844.522.5282

Medical Drug: MA (Processed by CVS)
Fax: 855.633.7613
Phone: 844.522.5282

Provider Portal

Things you will need to complete your account request

- Provider's NPI
- TIN
- Medical license number
- Office address
- Office name and/or facility
- Verify that the requestor's email address matches that of an email used within the office
- If a 3rd party biller, you will provide details of the affiliation with the provider office

The first associate requesting access will be established as the "Organization Manager" for the provider office (aka "Organization"). That associate will subsequently approve the access for all others within the office.

How to create a portal account

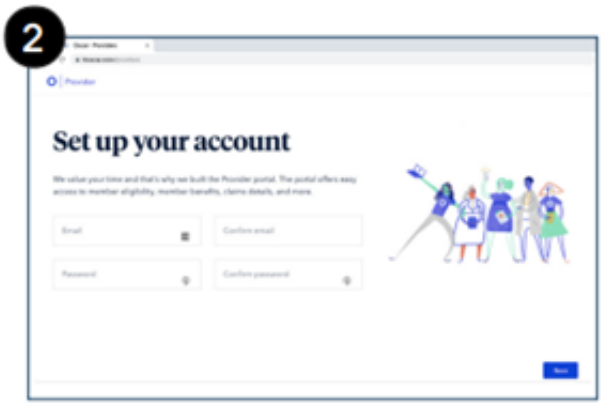
The provider portal is a tool that enables you to verify Member eligibility, review authorization requirements, set up electronic payments and more. Before you can access these features, you must set up an account on the portal and go through a verification process to ensure Member privacy.

1. Getting Started

Visit **myHFHP.org/4providers** and select the "Click To Get Started" link at the end of the "How to Create a Portal Account" instructions on the provider portal landing page.

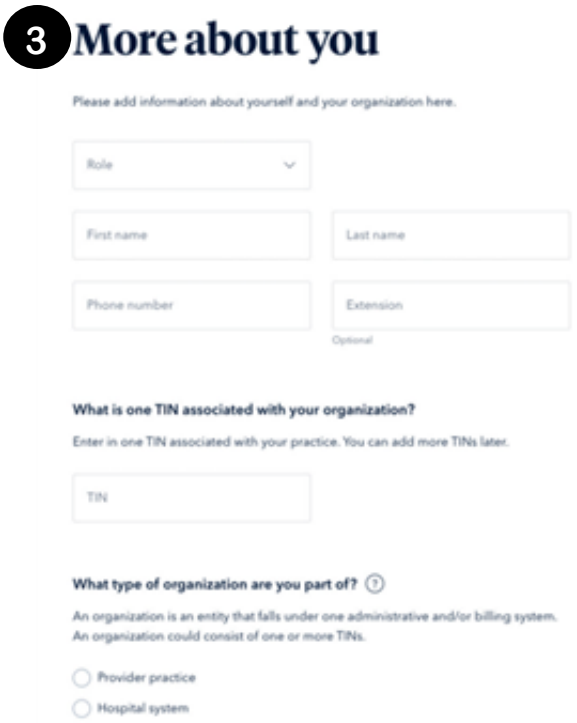
2. Set up your account

Enter your email address and password twice to confirm.



3. More about you

Complete this page by entering information relevant to you and your organization.

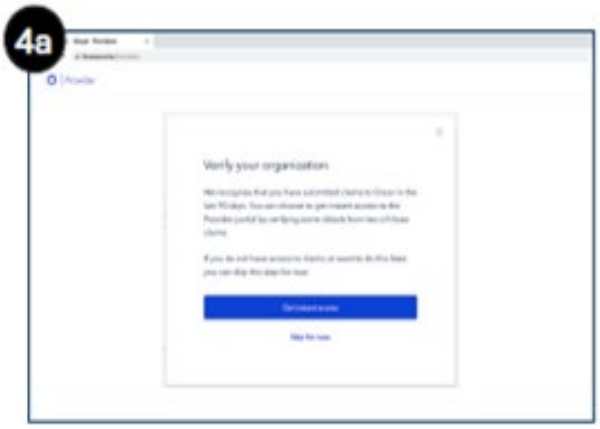


4. Verification

There are two methods of account verification, “Instant Access” and “Manual Verification”.

4a. Option #1: Instant access

If your organization has at least two claims on file from the last 90 days, you will be prompted to choose between “Get instant access” and “Skip for now”.



- If you select “Get instant access”, you will be prompted to enter details about two of your claims.
- These details include the claim ID, paid date of the claim, amount paid, and check number.
- If you don’t know where to find this information, you can click on the link to view a sample Explanation of Payment (EOP).
- If you select “Skip for now”, you will follow the manual verification process and receive a call within 3-5 business days to verify the information you entered and confirm your network status.

4b. Option #2: Manual verification

If your organization does not have two claims on file, you must complete the manual verification process. You will receive a call within 3-5 business days to verify the information you entered and confirm your network status.

5. Terms and Conditions

You must agree to the Terms and Conditions including the Terms of Service and Privacy Policy for provider portal use.

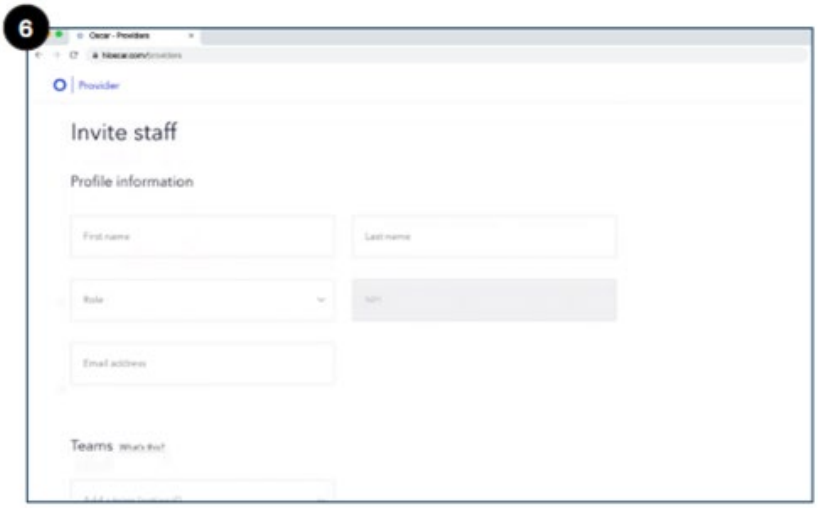
If you are an "Organization Manager", you must agree to the terms on behalf of yourself and your organization.

6. Almost there (Email verification)!

Once you have completed the registration, you will receive an email with a link to verify your email address. Click the link to verify your email. Use the drop-down menu on the top right side of the screen to invite staff.

When you invite staff, they will review an email asking them to create a password and login. As an Organizational Manager, you can assign staff to teams and regulate permissioning across your organization.

Using the top right drop-down menu again, you can view your organization. Here, you can add multiple Tax Identification Numbers (TIN) to the account, sign up for Automated Clearing House (ACH) payments, add a bank account and link TINs to different bank accounts.



Provider Portal FAQs

What is an organization?

An organization is an entity that falls under one administrative and/or billing system. An organization could consist of one or more TINs. Consider whether one portal administrator, called an organization manager, can cover all administrative needs for the organization.

Who should be the "Organization Manager"?

Typically, this is the primary office manager or in-house biller. If the practice is smaller, this may be the provider or nurse.

What are the responsibilities of an "Organization Manager"?

As an "Organization Manager" you are responsible for managing the organization's account as well as inviting, approving, and terminating users as necessary.

Can there be more than one "Organization Manager" in an organization?

Yes, there can be multiple organization managers. For security reasons, it is best practice to limit the number of organization managers.

What happens if the Instant Verification fails?

You have three attempts to correctly enter the data for two claims. If you are unable to provide the correct data, you will be moved to "Manual Verification". In this case, you will receive a call in 3-5 business days.

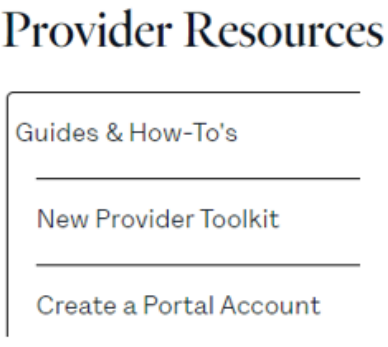
What if I don't receive the verification email?

Try clicking the "Resend email" button and acting on the email immediately when received. (Note: The verification link does expire after some time). If you are still having issues, it's possible your firewall is blocking the email. Please contact your information technology department to troubleshoot.

Provider Resources

On the provider portal there are quick links to "Guides & How-To's" documents for the most common operational information:

- Check eligibility and benefits
- Credentialing
- How to use the 835
- And more!



Consumer Assistance Notice

Should you need to bring an issue forward regarding your health plan, please contact your health plan directly, or one of the following:

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
888.419.3456

Subscriber Assistance Program
2727 Mahan Drive,
Mail Stop 26
Tallahassee, FL 32308
888.419.3456
800.955.8771 TDD/TTY
850.413.0900 Fax

Florida Department of Financial Services
200 E. Gaines St., Tallahassee, FL 32399-0300
850.413.3100

Florida toll-free Consumer Helpline: 877.693.5236

For contact information on your individual health plan, contact the Care Team. This information is provided as part of the Affordable Healthcare for Floridians Act of 2004.

Section 3: Claims

Claims must be submitted within the timely filing time frame specified in your contract. Health First Health Plans only accepts one Member and one Provider per claim.

All additional information reasonably required by Health First Health Plans to verify and confirm the services and charges must be provided on request. The Provider must complete and return requests for additional information within 35 calendar days of Health First Health Plans' request.

Timely Filing of Claims

Providers must claim benefits by sending properly completed claim forms itemizing the services rendered or supplies provided and the accompanying charges within the timely filing deadline. Health First Health Plans will not be liable for benefits if completed claim forms are not received within this time period. Claim forms must be used; canceled checks or receipts are not acceptable. Claims must be submitted within the applicable timely filing limits, or they will be denied.

Individual In-Network Providers

Providers should refer to their respective contracts for timely filing deadlines when submitting claims. Unless a different timely filing deadline is specified in the contract, the timely filing deadline for a Provider to submit claims will be 180 calendar days from the last date of service. All claims (electronic or paper) for services rendered after January 1, 2010, must be submitted within six months from the date of service. All providers should submit secondary claims within 90 days after the final determination by the primary insurer.

Medicare Advantage In-Network Providers

Contracted providers must submit claims within 365 calendar days from the last date of service unless otherwise specified in the provider's contract with Health First Health Plans. All providers should submit secondary claims within 90 days after the final determination by the primary insurer. All claims (electronic or paper) for services rendered after January 1, 2010 must be submitted within one year from the date of service.

Individual Out-of-Network Providers

Out-of-network providers in Florida shall submit all claims within 180 calendar days from the last date of service. All providers should submit secondary claims within 90 days after the final determination by the primary insurer.

Medicare Advantage Out-of-Network Providers

Non-contracted providers must submit claims within 365 calendar days from the last date of service. All providers should submit secondary claims within 90 days after the final determination by the primary insurer.

Claims submitted after the timely filing period expires will be denied unless proof of timely filing can be demonstrated according to the Proof of Timely Filing guidelines.

Individual Participating Providers: Timely Filing of a Primary Claim

Claims submitted (electronic or paper) to the Health Plan within ***six months*** from the date of service/discharge or the date the Provider has been furnished with the correct insurance information.

Medicare Advantage Participating Providers: Timely Filing of a Secondary Claim

Claims submitted (electronic or paper) to the Health Plan within 90 days after the final determination by the primary insurer.

For full details regarding our Timely Filing Policy, please contact your Provider Account Representative.

Claim Corrections and Late Charges

Individual Providers

Providers who believe they have submitted an incorrect or incomplete claim may submit an updated claim within 180 calendar days of the last date of service (the same timely filing limit established in the “Timely Filing Guidelines" section above).

Providers must submit a corrected claim when previously submitted claim information has changed (e.g., procedure codes, diagnosis codes, dates of service, etc.). When a claim is submitted as a correction or replacement, the entire claim must be submitted. Paper Centers for Medicare and Medicaid Services (CMS) 1500 corrected claim submissions must use frequency code 7 under Item 22 (Resubmission Code) and the corresponding original reference code field must list the original payor claim ID. Paper UB-04 corrected claims must be submitted with Claim Frequency Type 7 as the third digit under Type of Bill (Form Locator 04). Electronic corrected claims must be submitted in the 2300 loop; CLM05-1 thru CLM05-3 (CLM05-3 is the Frequency Type code). Updated claim submissions that do not have these codes may be denied as duplicate submissions. When an electronic claim is submitted for late charges, providers should use Frequency Type 5 (institutional claim use). Providers should utilize Frequency Type 8 for void or cancellation of a prior electronic claim

Medicare Advantage Providers

Providers who believe they have submitted an incorrect or incomplete claim may submit an updated claim within 365 calendar days of the last date of service (the same timely filing limit established in the “Timely Filing Guidelines" section above).

Providers must submit a corrected claim when previously submitted claim information has changed (e.g., procedure codes, diagnosis codes, dates of service, etc.). When a claim is submitted as a correction or replacement, the entire claim must be submitted. Paper CMS 1500 corrected claim submissions must use frequency code 7 under Item 22 (Resubmission Code) and the corresponding original reference code field must list the original payor claim ID. Paper UB-04 corrected claims must be submitted with Claim Frequency Type 7 as the third digit under Type of Bill (Form Locator 04). Electronic corrected claims must be submitted in the 2300 loop; CLM05-1 thru CLM05-3 (CLM05-3 is the frequency type code) Health First Health Plans 2022 Provider Manual - Updated as of 1.1.2022 (Claim Frequency Type Code). Updated claim submissions that do not have these codes may be denied as duplicate submissions. When an electronic claim is submitted for late charges, providers should use Frequency Type 5 (institutional claim use). Providers should utilize Frequency Type 8 for void or cancellation of a prior electronic claim.

The corrected claims process begins when you receive a notification of payment or explanation of payment from Health First Health Plans detailing the claims processing results. A corrected claim should only be submitted for a claim that has already paid, was applied to the patient's deductible/copayment, or was denied by the Plan, or for which you need to correct information on the original submission.

Electronic Corrected Claims

To submit a corrected claim electronically, providers will need to add a type of bill that contains a frequency type code of 5, 7 or 8, as well as the original Health First Health Plans claim ID number in their 837 file.

Frequency Type Codes Accepted
5-Late Charges (Institutional Claim use)
7-Replacement (replacement of a prior claim)
8-Void (void/cancel of prior claim)

The type of bill should be submitted in the 2300 loop; CLM05-1 thru CLM05-3 (CLM05-3 is the Frequency Type code). The original Health First Health Plans claim ID number should be submitted in 2300 loop: REF*F8 segment. Please note that when the frequency codes are 5, 7 or 8, the original ID should be the Health First Health Plans claim ID number.

Paper Corrected Claims

All corrected claims submitted on paper should be clearly marked "corrected" in blue or black ink in Box 19 of the 1500 form. **DO NOT USE RED INK.** Corrected claims must be signed by the Provider or requested by Health First Health Plans.

Corrected claims are not accepted via fax or as a dispute. They should be submitted to the following address:

Health First Health Plans
P.O. Box 66490
Phoenix AZ, 85082–6490

Best Practices for Resubmitting Original or Corrected Claim Filing

Adhering to the following claims filing best practices may reduce duplicate service denials and other unexpected processing results.

- Allow 30 days for claim processing to be completed before resubmitting a claim.
- Always check the provider portal and review for the status of the claim to ensure it is not currently being reviewed. Resubmitting a duplicate will only delay processing.
- When filing multiple-page paper claims:
  - Number pages (i.e., Page 1 of 3, Page 2 of 3, etc.)
  - Do not place the total charges for all services billed in the total charge field on each claim form. Only indicate the claim total charge on the last page.
  - File all services for a particular date of service on the same claim form as much as possible to prevent delays.
  - Do not mark claim "corrected" if additional information is requested, such as medical records or primary carrier Explanation of Benefits (EOB), **UNLESS** a change is made to the original claim submission.
  - Include **ALL** services to be considered for payment when submitting a corrected claim. This includes services that may have already paid on the original claim submission whenever possible to prevent delay in processing.
- A corrected claim should never be submitted as a dispute.
- When changing a Member ID number or date of service for a processed claim:
  - Submit a corrected claim canceling charges for the original claim, AND
  - Submit a new claim with the correct Member ID number or date of service.

Provider Disputes

A provider dispute is a written notice challenging, appealing, or requesting reconsideration of a claim (or a bundled group of similar multiple claims that are individually numbered) that has been denied, adjusted, or contested. It is also when a Provider seeks resolution of a billing determination or other contract disputes or disagrees with a request for reimbursement of an overpayment of a claim. A corrected claim should never be submitted as a dispute. Providers

may submit disputes by sending the dispute via fax, mail or through the provider portal. Copies of the Provider Claim Dispute Request form are available on the provider portal at **myHFHP.org**. The preferred method of submitting a dispute is by fax.

As a contracted provider you can file a post-service dispute when you disagree with payment(s) you received after rendering services to our members. Health First Health Plan will deny any post-service dispute for services we've denied through our pre-authorization process and/or for services that require an authorization but for which there is no authorization on file unless otherwise specified in the provider contract. Payment disputes and supporting documentation can be submitted via the following channels:

Health First Health Plans	Fax: (IFP) 888.977.2062
P.O. Box 66490	Fax: (MA) 866.806.4650
Phoenix, AZ 85082-6490	Provider portal: **myHFHP.org**

Upon receipt of the payment dispute and relevant documentation, Health First Health Plans will perform a full review of the claim in question. A resolution to the Claims Payment Dispute will be rendered and communicated to the provider within 60 calendar days. The notification will include sufficient information about the disputed claim(s) and any change in reimbursement(s) made to you. All decisions made in connection with our payment dispute reviews are final.

For more information about the complaint submissions process or payment disputes, contact the Care Team:

Entity	**Telephone Number**
AdventHealth Advantage Plans	844.522.5278
Health First Health Plans	844.522.5282
TTY	800.955.8771

Medicare Reopening Guidelines

All written requests for reopening must be submitted within ***one year*** from the date of original determination, or up to four years with good cause. Good cause is established when an obvious error was made in the original decision, or there is new and material evidence that was not available at the time of the original decision.

- Non-contracted providers should submit reconsideration requests within ***60 days*** from the date of original determination.
  - If the dispute is resolved fully in the Provider's favor, the claim will be adjusted accordingly, and a new Remittance Advice will be generated.
  - If the dispute is not resolved fully in the Provider's favor and the first and second levels of dispute are upheld, a letter will be sent to the disputing Provider advising of the reason(s) for the adverse decision and the Provider's right to request *Independent Payment Dispute Resolution* through First Coast Service Options (FCSO).

- Providers may request review of an adverse dispute decision by filing a request for *Independent Payment Dispute Resolution* through FCSO with the required documentation, including a copy of the Health Plan's unfavorable redetermination or, if available, evidence that the Health Plan did not respond to the dispute within 60 days.
- FCSO will review the Dispute and notify the Provider and the Health Plan of the decision.
- If FCSO requests materials related to a Dispute from the Health Plan, the materials must be sent within seven calendar days and received on or before the eighth day.
- All Medicare Advantage Provider Disputes that do not qualify under the definition of a reopening will be forwarded to a Member Advocate, who will apply the Medicare Appeal process in accordance with GA-05 Medicare Part C Reconsideration.
- The Provider's Explanation of Payment meets as approval of notice.

For a dispute or reopening to be valid and eligible for reconsideration, the documentation should contain the following elements:

- Member's Name
- Member's ID Number
- Provider's Name
- Provider's Address
- Date of Service
- Claim Number and Line Item at issue
- Medical documentation if applicable to establish medical necessity
- Signature of Provider or authorized representative
- A request for reconsideration, including rationale for payment (A duplicate claim or Remittance Advice submitted without a specific request for review and the reason will be returned.)

Individual Provider Dispute Guidelines

A provider wishing to submit a payment dispute may do so using the **Dispute Resolution Form** or other written format submitted by mail, through Health First Health Plans' electronic provider portal, or via fax within ***six months*** of a claim processing decision. A copy of the Dispute Resolution Form can be found in the appendix of this manual and on the Health First Health Plans' website. This submission will trigger the Dispute Resolution Process. Once the Dispute Resolution Form is received, an acknowledgement letter will be sent to the Provider. Health First Health Plans will resolve or seek additional information needed to resolve disputes within 60 calendar days.

Dispute Resolution Forms and other related communications can be sent via the following:

Health First Health Plans
P.O. Box 66490
Phoenix, AZ 85082-6490

Fax: (IFP) 888.977.2062
Fax: (MA) 866.806.4650
Provider portal: **myHFHP.org/**

Medicare Advantage Provider Dispute Guidelines:

As a contracted provider you can file a post-service dispute when you disagree with payment(s) you received after rendering services to our members. Health First Health Plan will deny any post-service dispute for services we've denied through our pre-authorization process and/or for services that require an authorization but for which there is no authorization on file unless otherwise specified in the provider contract. Payment disputes and supporting documentation can be submitted via the following channels:

Health First Health Plans	Fax: (IFP) 888.977.2062
P.O. Box 66490	Fax: (MA) 866.806.4650
Phoenix, AZ 85082-6490	Provider portal: **myHFHP.org**

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Upon receipt of the payment dispute and relevant documentation, Health First Health Plans will perform a full review of the claim in question. A resolution to the Claims Payment Dispute will be rendered and communicated to the provider within 60 calendar days. The notification will include sufficient information about the disputed claim(s) and any change in reimbursement(s) made to you. All decisions made in connection with our payment dispute reviews are final.

For more information about the complaint submissions process or payment disputes, contact the Care Team:

Entity	**Telephone Number**
AdventHealth Advantage Plans	844.522.5278
Health First Health Plans	844.522.5282

Section 4: Medical Management

Authorization Requests and Communication

To confirm authorization requirements for a specific code or service or to submit an authorization request, use the provider portal at **myHFHP.org** or use the phone numbers below. Providers can use these phone numbers to request authorization and check the status of an existing authorization. For services where utilization review (UR) is delegated, you will be transferred to or instructed to contact the appropriate vendor. Providers may also request authorization by faxing the Authorization Request Form.

Product	**Fax Number**
Individual	844.965.9053
Medicare	833.554.9046

Our Utilization Management (UM) Program affirms the following:
UM decision making is based only on appropriateness of care and service and existence of coverage. There are no rewards to providers or employees who perform UR for issuing denial of coverage or for encouraging underutilization.

All determinations or requests for more information to make an initial UR determination are made in a timely fashion appropriate for the Member's specific condition, not to exceed the timeframes required by the National Committee for Quality Assurance (NCQA) and the state of Florida and/or federal regulations. Decisions are communicated verbally and/or in writing to members and providers as required by regulations.

A UM approval will not be reversed when the Provider reasonably relied upon written or oral authorization by Health First Health Plans (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or fraud.

Any adverse determinations (medical necessity denials) are reviewed, and decisions are ultimately made by a physician or psychologist with an active license by a state licensing agency in the United States.

Health First Health Plans promotes consistent application of review criteria across its UM staff by conducting regular internal audits of determinations made by all clinical UM staff as well as annual inter-rater reliability testing (IRR). In IRR testing, clinicians are given the same clinical scenario and asked to demonstrate their decision-making so that differences in determinations can be used as the basis for remediation and training.

Staff are available at least 8 hours per day during normal business hours and outside normal business hours for urgent requests. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues. TDD/TTY services and language assistance are available for callers as well.

Services Requiring Authorization

The list of services subject to PA can be accessed online at **myHFHP.org**. It is important to submit any elective or pre-service requests in advance to ensure everything is in place for your patients to get the right care. Please note that the list of services within each category might not be exhaustive. To confirm requirements for a specific code or service, request authorization, or to check the status of an existing authorization, reference the authorization tool at **myHFHP.org**. For Health First call 844.522.5282 or for AdventHealth call 844.522.5278. Authorization requests may also be submitted by faxing the Authorization Request Form to 844.965.9053.

Review for certain services is delegated to eviCore healthcare. To access eviCore's clinical criteria and authorization request forms, please visit **evicore.com/healthplan/Oscar**. For any other services not indicated in these resources, you can call 844.522.5282 for Health First Health Plans or 844.522.5278 for AdventHealth Advantage Plans. For instructions on confirming authorization requirements for a specific code or service, please see the above "Authorization Requests and Communication" section. For services where UR is delegated, you will be transferred to or instructed to contact the appropriate vendor.

The services subject to prior authorization (PA) are outlined on the provider portal. If PA is not obtained, they are subject to post-service (retrospective) review. Some services that may be a part of an ongoing course of treatment may also be subject to concurrent review. Review requirements (PA, concurrent, and/or retrospective review) for behavioral health and substance abuse and pharmacy are subject to the policies and procedures of Optum and CVS/Caremark, respectively.

Inclusion of a benefit in the Authorization List is not a guarantee of coverage. Coverage of these benefits may vary by plan, and the Authorization List is subject to change. To verify coverage or authorization requirements, please call 844.522.5282 for Health First Health Plans or 844.522.5278 for AdventHealth Advantage Plans.

Case Management Services listed below are available to members of Health First Health Plans.

Complex Case Management

Complex Case Management is a collaborative relationship between a Member, Case Manager and Primary Care Provider (PCP) designed to help the Member regain optimum health or improved functional capability. It involves comprehensive assessment of the Member's condition, teaching the Member self-management skills, management of multiple disease states and any emerging risks, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Care Coordination

Care Coordination is case management provided to members with conditions that require assistance with access to services or referrals to resources.

Transition of Care Program

The Transition of Care Program provides personalized assistance to members who are discharged from a hospital or Skilled Nursing Facility to a self-care setting such as home or an Assisted Living Facility. The goal of this service is to ensure our members have a safe transition home. A safe transition to home will help ensure our members have the best possible clinical outcome as well as prevent a readmission to the hospital and any unnecessary emergency room visits. Our case managers work with members to ensure they receive medication as prescribed and understand how to take them after being discharged. They will also make sure follow-up appointments have been scheduled and ensure other treatments or services ordered at discharge are being received and understood.

Disease Management

Our Disease Management program is offered to eligible members with diabetes or heart failure. Members will receive ongoing collaboration with our care team to help ensure the most appropriate goal-oriented treatment plan, tools, and resources are in place to successfully manage their condition. These include education, self-monitoring techniques, support coordinating health care needs, and identifying community resources. The goal is to help members with these chronic conditions recognize danger signs early and improve their quality of life through self-management skills to help promote wellness and health.

Visit **myHFHP.org/yourhealth** to explore additional program and to request enrollment in a Care Management Program.

For more information, contact the Care Team toll-free Monday through Friday from 8 a.m. to 6 p.m. at:

Entity	**Telephone Number**
AdventHealth Advantage Plans	844.522.5278
Health First Health Plans	844.522.5282
TTY	800.955.8771

Member and Provider Appeal Processes FAQs

The following content summarizes first-level appeal processes for members and providers. Additional steps in the process vary by product line and are communicated with first-level decisions and in applicable contracts.

Member Appeals

A Member or valid representative has the right to appeal any adverse coverage determination (denial of coverage). For Individual members, cost-share disputes are initially handled as grievances, with appeal rights provided if an unfavorable decision is made.

Who can file appeals?

- The Member may file appeals.
- The Member's legal representative can, such as a Power of Attorney or Health Care Surrogate.
- The Member's authorized representative can file appeals.
- The representative must be appointed in writing. An Appointment of Representation form is available on our website or from the Care Team.
- The treating or prescribing physician may file an appeal on the Member's behalf.

How are appeals filed?

- Standard appeals must be filed in writing.
- Expedited appeals may be filed verbally.
- The expedited appeal process is for pre-service situations in which the Member's health would be jeopardized by applying the standard resolution timeframe.

Where should appeals be sent?

Product	Mailing Address	Fax	Email
Individual	Health First Health Plans P.O. Box 62378 Phoenix, AZ 85082	888.977.2062	**hf-providers@plusocar.com**
Medicare	Health First Health Plans P.O. Box 62378 Phoenix, AZ 85082	833.554.9047	**hf-providers@plusocar.com**

Providers may file expedited appeals on a member's behalf by calling 844.522.5282 Monday through Friday from 8 a.m. to 6 p.m.

How quickly must appeals be filed?

HMO/POS Members – 365 days year from original decision
Individual members – 365 days from original decision
Medicare members – 60 calendar days from original decision

How quickly are appeals resolved?

Expedited Appeals – 72 hours
Standard Pre-Service Appeals

- Individual – 15 calendar days
- Medicare members – 30 calendar days (7 days for medication requests)

Standard Post-Service Appeals

- Individual – 30 calendar days
- Medicare members – 60 calendar days

An extension may apply in certain circumstances when additional information is needed.

Who can review appeals?

- **Benefit appeals** (coverage decisions not based on medical necessity) are reviewed by an appropriate decision-maker, which may include management team members or their designees.
- **Medical necessity appeals** will be initially reviewed by an appropriate clinical professional, who may approve coverage if indicated. Only a physician may deny coverage based on medical necessity.

Appeal reviewers may not have been involved in any prior decision on the coverage request and may not be a subordinate to the original decision-maker.

What are the types of independent external reviews?

- **Individual Plans:** External binding review is available for appeals that involve medical necessity or the determination of whether a service is experimental or investigational. Expedited external review may be requested at the same time an expedited appeal is requested through the health plan or after the internal appeal process has been completed.
- **Medicare Plans**: Multiple additional levels of independent review are available through MAXIMUS Federal Services, an Administrative Law Judge, and the Medicare Appeals Council.

Provider Appeals (Provider Claim Disputes)

The provider claim dispute process is separate and distinct from the member appeal process and responds to provider disputes regarding the denial of payment or the amount of payment.

Who can file provider claim disputes?

- Contracted providers
  Note: Non-contracted Medicare providers may file appeals like the member appeal process above, but must waive the right to bill the Member regardless of the outcome of the appeal.

How are provider claim disputes filed?

Provider claim disputes must be filed in writing, preferably using the form located on our website at **myHFHP.org**.

Where should provider claim disputes be sent?

Product	Mailing Address	Fax	Secure Website (Preferred)
Individual	Health First Health Plans P.O. Box 62378 Phoenix, AZ 85082	888.977.2062	**myHFHP.org** Submit disputes using your secure portal account.
Medicare	Health First Health Plans P.O. Box 62378 Phoenix, AZ 85082	833.554.9047	

How quickly must provider claim disputes be filed?

Within 60 calendar days from the original claim decision

How quickly are provider disputes resolved?

Within 60 calendar days

Other Questions?

For more information, contact the Care Team toll-free Monday through Friday from 8 a.m. to 6 p.m. at:

Entity	Telephone Number
AdventHealth Advantage Plans	844.522.5278
Health First Health Plans	844.522.5282
TTY	800.955.8771

Section 5: Quality Management

Health First Health Plans will ensure the following:

- The provider network is sufficient in numbers and types of practitioners.
- There are mechanisms in place to assure the accessibility of primary care services, behavioral health services and member services.
- The accessibility of preventive, routine primary, urgent, after-hours and behavioral health care

Accessibility

Accessibility is the timeliness within which a member of a managed care organization can obtain available services. Service refers to both telephone access and ease of scheduling appointment.

Availability

Availability is the extent to which a managed care organization has practitioners of the appropriate type and number distributed geographically to meet the needs of the membership.

Standards of accessibility of services:

- Preventive care appointments – seen as soon as possible or within 30 days
- Routine primary care appointments – seen within 72 hours for symptomatic care and within 30 days for non-symptomatic care
- Urgent care appointments – seen within 24 hours
- Emergency care appointments – seen immediately within one hour
- After-hours appointments – urgent calls returned within 30 minutes, non-urgent calls returned within 60 minutes
- Appointment wait times – professional evaluation is required to be conducted within one hour of the scheduled appointment time (if the wait time is greater than 30 minutes, an alternative appointment and explanation should be offered)
- Key elements of health plan's telephone Care Team – average speed of answer of less than 30 seconds, 80% of calls answered within 30 seconds, and abandonment rate of 3% or less
- Behavioral health standards (delegated to health plan's managed behavioral healthcare organization) include the following:
- Member with a life-threatening emergency need is seen immediately
- Member with non-life-threatening emergency needs has access to care within 6 hours
- Member with urgent needs has access to care within 48 hours
- Member has access to routine office visit within 10 working days

Members have telephone access to screening and triage. Callers reach a non-recorded voice within 30 seconds, and abandonment rates do not exceed 5% at any given time. Health First Health Plans will compare access standards for Primary Care Providers, High Impact Specialists High Volume Specialists, and facility providers against the CMS Health Services Delivery requirements by county.

Strategic Partnerships and Improvements

Health First Health Plans operates as a contracted network model doing business with a network of employed and independent contracted providers, suppliers and facilities that meet our rigorous credentialing standards. We also delegate certain quality improvement functions to qualified vendors.

Oscar Health

In 2021, we entered into an Administrative Services Agreement (ASA) with Oscar Health to combine our expertise with the best-in-class technology platforms of Oscar Health. Health First Health Plans and Oscar Health are both customer-focused organizations dedicated to providing easy access to high-quality care technology that makes using the healthcare system easier.

Our network providers gained access to a provider portal that is robust and easy to navigate. As a part of the ASA, we will work collaboratively on medical records retrieval and other Quality Programs such as Healthcare Effectiveness Data and Information Set (HEDIS) and Clinical Documentation Integrity to improve the provider's operational experience. Our members gained access to Oscar Health's technology platform while having access to the same providers and services they know and trust.

AdventHealth

We continue to strengthen our partnership with AdventHealth to offer health plans branded as "AdventHealth Advantage Plans" (AHAP) in select markets. AdventHealth's Population Health Services Organization plays a vital role in provider network contracting and management, and clinical case management of members under the AHAP brand. This partnership will create a Super Regional IDN – meaning, our facilities, health plans, and capabilities combined will stretch from the Gulf Coast to the Space Coast.

Privia Health

In Fall 2019, the Health First Medical Group entered a partnership with Privia Health, a national physician practice management and population health technology company. Privia assisted in implementing a comprehensive electronic medical record system, providing population health resources, and creating an enhanced seamless experience for customers choosing Health First Health Plans for their care. About half of our membership is attributed to these providers, which allows them to have access to myPrivia – an online platform where members can access appointment scheduling, test results, doctor's notes, and several other functions that will improve their healthcare experience.

Quality Improvement (QI)

To monitor, oversee, and evaluate the providers in the provider network, several committees were formed. The Physician Advisory Committee (PAC), Credentialing, and Peer Review Committees are physician-led committees that are composed of contracted providers from various specialties, including behavioral health. They are chaired by a Medical Director (or delegate) with specific purposes as follows:

Physician Advisory Committee

Purpose:

- Overseeing clinical quality improvement activities
- Reviewing and approving clinical criteria (e.g., Medical Policies) used in utilization management processes
- Assessing new technology for potential coverage
- Serving as an advisory committee to Health Plan leadership for issues pertaining to health care delivery and improvement opportunities

Credentialing Committee

Purpose:

- Reviewing and approving the Health First Health Plans' Credentialing Plan and associated procedures
- Reviewing credentialing and recredentialing applications that are not considered "clean" based on Health First Health Plans' criteria to make credentialing recommendations
- Addressing quality issues identified through the peer review process in credentialing decisions
- Ensuring credentialing decisions are nondiscriminatory
- Ensuring all relevant data is used in making credentialing decisions, including, but not limited to, information contained in the application, information from internal Health First Health Plans' sources, and information from third-party sources

Peer Review Committee

Purpose:

- Evaluating practitioner performance in an environment that is confidential, unbiased, and focused on improvement
- Reviewing issues related to the quality of care and service provided to Health First Health Plans' members
- Making recommendations for corrective action as needed considering severity of findings, and following up to ensure corrections have been made
- Reporting findings to the Credentialing Committee as applicable
- Reporting to external licensing and regulatory bodies as required

The objective of peer review is to monitor important aspects of care and identify potential issues and risks, and to identify, monitor and track them to facilitate medical management and desired

healthcare outcomes. Peer Review matters will be investigated when necessary and appropriately documented, regardless of a Provider or Clinician's status.

Peer Review matters contemplate issues or risks that existed, currently exist, or would reasonably exist in the future; and no reference to the past, present, or future shall be regarded as exclusive of the others.

A Peer Review file on each Provider and Clinician will be maintained by Health First Health Plans, under the jurisdiction of the Chief Executive Officer of Health First Health Plans, Medical Director, and the Peer Review Committee (PRC) or their delegate. The Peer Review file is confidential. The Peer Review process and file may contain:

- All materials regarding the evaluation of credentials
- All current monitoring reports; and
- The collective information used in an evaluation involving a Provider or Clinician

A Clinician has the right to examine the portions of the Peer Review file that show the Clinician's current privileges and any formal findings by the PRC at any reasonable time during the Plan's ordinary working hours, subject to confidentiality and privilege provided under Florida and federal laws. The individual may respond in writing to anything in the file and have the response included in the Peer Review file. They also have the right to a Fair Hearing.

Fair Hearing process:

Any providers who are subject to an Adverse Action have the right to a fair hearing related to such decisions. Providers and Health First Health Plans agree to participate in this process in a professional and courteous manner.

Providers who are subject to an "Adverse Action" may seek a hearing as provided for in the Fair Hearing Policy.

Adverse Action: When Plans take an action materially reducing, suspending, or revoking the Clinical Privileges of a Clinician for clinical or professional reasons for more than fourteen (14) days in the Plans, that is an Adverse Action. Granting limited privileges to a new applicant is not considered an Adverse Action. Prepayment review, PA or similar activities are not Adverse Actions. Termination of a Provider Participating Agreement for breach of contract, termination with or without cause, billing matters and coding matters are not Adverse Actions.

Adverse Event: An Adverse Event is any undesirable experience, outcome, or occurrence, associated with a Provider or Clinician. Additionally, failure to self-report an Adverse Event to Plans for any inappropriate behavior, action, or non-action will automatically be considered an Adverse Event.

For a complete copy of the Health First Health Plans policy, please contact the Credentialing Department at **HFHPCredentialing@HF.org**.

Population Health Management (PHM) Program

We use NCQA's PHM Standards to develop a comprehensive system to address member needs across the care continuum, from the healthy to the chronically ill. The primary goal of the PHM Program is to use data-driven, patient-centric solutions to improve community health and member experience while reducing overall costs.

PHM initiatives are monitored and managed by the Clinical Operations, HEDIS Operations, and Stars and Accreditation teams to ensure alignment.

Our PHM strategy is to use internal and public data to assess our membership to develop programs for members, providers, and business partners that address four areas of focus:

1. Keeping members healthy
2. Managing members with emerging risk
3. Patient safety or outcomes across settings
4. Managing multiple chronic illnesses

Serving a Diverse Membership – Cultural Competency

The Health Plan's service area is primarily populated by White/Caucasian, English-speaking residents (approximately 85% overall).
Approximately 10% of the overall population is Black/African American. The Hispanic/Latino population varies more widely by county, ranging from approximately 10% in primary urban counties to 43% in rural Hardee County.

We comply with all nondiscrimination laws and provide a notice with all critical documents of the availability of translation into other languages. Live phone translation services, as well as all printed documents, are available from a contracted vendor through the Care Team Call Center, with documents translated into other languages as required. Currently, Spanish is the most frequently needed translation, and the Call Center employs bilingual associates in addition to the contracted translation services. As we continue to grow into more diverse service areas, additional strategies may be implemented.

Delegation of Quality Improvement Activities

All vendors are required to follow the applicable requirements set forth by NCQA, CMS, Florida's Agency for Health Care Administration, and any other federal or Florida agency. Vendors with delegated responsibility for NCQA standards are monitored according to applicable delegation oversight requirements and Health Plan policy. Vendor reports are reviewed at regular intervals as required by NCQA and evaluated for improvement activities. Additionally, all critical vendors are routinely monitored by our Vendor Management Office for compliance with Service Level Agreements and other contractual requirements.

Section 6: Credentialing

Health First Health Plans requires credentialing/recredentialing for all providers who deliver services in an office setting, physician assistants and nurse practitioners who have their own patient panel under a PCP or OB/GYN and those who work in a walk-in/urgent care setting.

The credentialing/recredentialing process ensures that each Health First Health Plans provider is qualified by education, training, licensure, and experience to deliver quality medical services. All providers who are to be considered for credentialing or who are already credentialed must meet specific criteria for their specialty (e.g., board certification status, hospital privileges).

Once an application for credentialing/recredentialing has been received and reviewed, it will go before the Medical Director for review/approval if it meets “Clean File” criteria. Files that do not meet the “Clean File” criteria are taken to the Credentialing Committee for discussion and review. Once approved by the Medical Director or Credentialing Committee, files are submitted to the Health First Board of Trustees (Board) for final approval.

The Board’s decision is communicated to the provider within 30 days by letter sent via email, fax, or postal mail. The letter will contain the date approved by the Medical Director and Board and the period in which the provider’s credentials (initial or recredentials) are active.

For a complete copy of the Health First Health Plans Credentialing Plan, please contact the Credentialing Department at **HFHPCredentialing@HF.org**.

Section 7: Medical Records

Health First Health Plans may perform medical record audits to investigate potential quality issues or may randomly choose primary care practitioners for an audit.

Providers that deliver primary care services include the following: family medicine, general medicine, internal medicine, pediatrics, and obstetrics/gynecology (when acting as a PCP). This provider manual sets forth the medical record standards criteria used to evaluate performance applicable to such practitioners.

In general:
Accurate medical records are expected to be readily available to members and Health First Health Plans. Medical records are expected to be confidential, abiding by state and federal HIPAA rules. They should be stored securely, with access granted to authorized personnel only. Office staff are expected to receive annual training on confidentiality.

When deficiencies in medical record keeping are discovered, Health First Health Plans will implement corrective action or performance improvement plans with the practitioner.

In the Medical Record:

1. Medical record documentation from a face-to-face or virtual encounter visit must be signed and include the provider's credentials. Note: Medical records should be signed "promptly" by the rendering provider. This is defined as within 180 calendar days of the encounter.
2. Every page in the record contains the patient's name or ID number.
3. Documentation of allergies or No Known Drug Allergies and adverse reactions are prominently displayed in a consistent location.
4. All presenting symptom entries are legible, signed and dated, including phone entries.
    a. Dictated notes should be signed or initialed to signify review. (If initialed, a signature sheet for initials is noted.)
5. The important diagnoses are summarized and highlighted.
6. A problem list is maintained and updated for significant illnesses and medical conditions.
7. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
8. History and physical exam identify appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
9. Past medical history is documented including significant illnesses, accidents, and operations, and prenatal and birth information for pediatric members.
10. Each visit notation includes the following:
    a. **Subjective data**: Chief complaint (or reason for visit)
    b. **Objective data**: Focused (problem-specific) physical examination
    c. **Assessment**: Diagnosis or Impression
    d. **Plan**: Treatment plan, goals

11. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see documentation of appropriate follow-up recommendations and/or non-compliance to the care plan.)
    a. Note that follow up care is scheduled for abnormal findings.
12. Referrals to specialists are clearly documented.
13. Follow up report received and acknowledged when referred specialist care was obtained.
14. Documentation of Advance Directive, Living Will or Power of Attorney discussion in a prominent part of the medical record for adult patients is encouraged.
15. Should the Member decline an Advance Directive, documentation of the Member decision shall be documented.
16. Continuity and coordination of care between the PCP, specialty physician(s) (including behavioral health) and/or facilities must be included if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include but are not limited to progress notes/reports from consultants, discharge summaries following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/provider reports.
17. Age-appropriate routine preventive services/risk screenings are consistently noted, i.e., childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent, or legal guardian of such screenings/immunizations, in the medical record.
18. Appropriate screening and subsequent coordination for autism spectrum disorder

Section 8: Risk Management

For Risk Management issues involving Health First Health Plans members, contact the System Vice President, Risk and Information Security Officer at 321.434.4383.

The Health Plan utilizes a formal risk management program to investigate and analyze the frequency and cause of adverse incidents which cause harm to a member and develop appropriate measures to minimize risk of injuries to members.

As part of this program, providers are contractually required to report all adverse incidents affecting members to the licensed risk manager immediately upon discovery, but no later than 48 hours after detection or notification.

The following adverse incidents should be reported using the Adverse Incident Report Form:

- Adverse or untoward incident – an event over which healthcare personnel could exercise control and:
  - Is associated in whole or in part with medical intervention rather than the condition for which such intervention occurred, and
  - Is not consistent with or expected to be a consequence of such medical intervention, or
  - Occurs because of medical intervention to which the patient has not given his informed consent, or
  - Occurs because of any other action or lack thereof on the part of the facility or personnel of the facility, or
  - Results in a surgical procedure being performed on the wrong patient, or
  - Results in a surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong-site or wrong-procedure surgeries, and procedures to remove foreign objects remaining from surgical procedures, and

Causes injury to a patient as defined below:

- Injury – Any of the following outcomes when caused by an adverse incident:
- Death, or
- Brain damage, or
- Spinal damage, or
- Permanent disfigurement, or
- Fracture or dislocation of bones or joints

Section 9: Clinical Practice Guidelines

Network partners for behavioral health and substance abuse, pediatric dental, pediatric vision, and prescription/specialty pharmacy services are listed below. Providers of these services must be in the respective partner's network and claims must be submitted to the listed addresses. These network partners also handle contracting, credentialing and in some instances, utilization management and review for these services. For more information on clinical practice guidelines unrelated to our network partners, visit the provider portal at **myHFHP.org**.

Behavioral Health and Substance Abuse Services
Optum
P.O. Box 30757
Salt Lake City, UT 84130-0757
Electronic Payor ID: 87726

Pediatric Vision Services
Davis Vision Care Processing
P.O. Box 1525
Latham, NY 12110

Pediatric Dental Services
LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92779
Electronic Payor ID: CX083

Prescriptions / Specialty Pharmacy
CVS/Caremark Claims Department
P.O. Box 52000 (MC 109)
Phoenix, AZ 85072-2000

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

The HIPAA Privacy Rule requires healthcare providers and health plans to develop and distribute a notice that provides a clear, user-friendly explanation of customers' rights with respect to their personal health information and the privacy practices related to that information.

Our Pledge

This notice applies to all customers receiving services from Health First, Inc., Health First Medical Group, LLC, Health First Privia Medical Group, LLC[1] and/or Health Plan[2]. Health First is committed to improving the wellness and health of our customers and community. We want you, our customers, to feel supported and informed about your care and coverage. This includes explaining how we use, manage and safeguard your information and your rights and choices related to your information.

*If you have any questions about this notice, please contact the Health First Privacy Office at **321.434.7543**.*

Your Information

In this notice, information refers to any information that identifies you, as a current or former Health First customer, and relates to your health or condition, your healthcare services, payment or coverage for those services. It includes claims and coverage information, and health information, like diagnosis and services you received. It includes demographic information like your name, address, phone number and date of birth. It includes information that comes from you or results from you doing business with us, our affiliates or others, such as enrollment, prior approvals, referrals, coverage determinations, claims and payment information.

How we safeguard your information

We allow access to your information by our workforce members but only to the extent they need that information for treatment, payment, healthcare operations and/or to administer your health plan and benefits, comply with legal or accreditation requirements, or as otherwise allowed by law. As such, and in order to provide our customers with necessary, appropriate, and timely continuity of care, Health First entities have several electronic platforms, systems, and applications that share your information throughout our Integrated Delivery Network ("IDN") and the community where needed and permitted for treatment, payment and healthcare operations and in accordance with applicable law.

We maintain physical, electronic and administrative safeguards designed to protect your information and prevent unauthorized access.

How do we typically use and share your information?

We may share your information without your written authorization for the following purposes:

For Treatment:
To share with healthcare providers (doctors, dentists, pharmacies, hospitals and other caregivers) for your treatment or to coordinate preventative health, early detection and disease and case management programs.

Example: Your doctor sends us information about your diagnosis and treatment plan so we can help arrange for additional services.

Please note, that we do not need your permission to share your information in a medical emergency, if you are unable to give us permission due to your condition. Also, the organizations covered by this notice do not need your permission to share your information with each other, as long as it is for a permitted purpose.

For Payment:
To pay or receive payments for care that you receive.

Example: We may contact your providers to coordinate your benefits and to confirm eligibility and coverage or we might contact your health plan to pay for services you received at our facilities.

For Healthcare Operations:
To support daily business activities for healthcare operations.

Example: We use and disclose your information to

tell you about plan benefits, treatment alternatives or health-related products and services. We use your information for quality management, improvement activities, care coordination and for underwriting purposes. We also use your information to contact you regarding your appointments or for fundraising activities. If you do not want to be contacted by Health First for fundraising efforts, you must notify the Health First Foundation in writing at **ATTN: Foundation Gift and Data Specialist, 1350 S. Hickory St., Melbourne, FL 32901** or by phone at **321.434.7353**. Unless you tell us otherwise, we may include some limited information about you in our directory. This information might include your name, location and general condition. We might share this information with your family members and friends unless you tell us otherwise.

To administer your plan:
We may share your information with our affiliates (also known as related organizations) that help us administer and manage our health plan. We may also share your information with non-affiliated (non-related) third parties permitted by HIPAA. These organizations are generally known as Business Associates. Health First contracts with these Business Associates to provide certain products or services on our behalf. Business Associates are required by law to safeguard your information the same way we do.

Other uses and disclosures:
We may also share your information with other third parties, including regulatory authorities, government agencies or law enforcement, as allowed or required by law.

The Health Plan in providing fully insured benefits to a group health plan, or helping administer the benefits of a self-insured group health plan, may, if requested, share limited information with the sponsor of your group health plan, for plan administration purposes, if certain privacy requirements are met.

Example: For a fully insured plan, the Health Plan may share certain statistics with your employer to explain the premiums we charge.

We use or share your information if state or federal law requires it.

Public health and safety issues:
We share your information with public health authorities or other authorized agencies in certain situations such as:

- Prevent disease
- Help with product recalls
- Report adverse reactions to medications
- Report suspected abuse, neglect, domestic violence or crimes in our care locations
- Prevent or reduce a serious threat to anyone's health or safety
- Help with health system oversight, such as audits or investigations
- Comply with special government functions such as military, national security, presidential protective services and disclosures to correctional facilities.

Respond to organ and tissue donation requests:
We use and share your information to help with organ or tissue donation.

Work with a medical examiner or funeral director:
We share your information with a coroner, medical examiner or funeral director.

Handle workers' compensation:
We use and share your information for your workers' compensation claims.

Respond to lawsuits and legal actions:
We can use and share your information for legal actions, or in response to a court or administrative order, or other lawful process. We can share your information with authorized law enforcement officials.

Organized Health Care Arrangement (OHCA)

Health Plan participates in two distinct Organized Health Care Arrangements (OHCA) under the Health Insurance Portability and Accountability Act (HIPAA). An OHCA is an arrangement that allows covered entities, which are a healthcare provider, health plan or healthcare clearinghouse, to share Protected Health Information (PHI) about their customers, person receiving services, or plan members to provide healthcare services, to perform payment and to perform healthcare operations. Health Plan participates in one OHCA with AdventHealth and its Florida-based affiliates. Health Plan also participates in a separate OHCA with other Health First, Inc. entities. Please contact our Privacy Office if you would like to know what networks or accountable care organizations Health Plan participates in.

Uses and disclosures that require your authorization:

For any other purposes not described in this document, we must obtain your written authorization to use or share your information. For example, we would need your authorization:

- For uses and disclosures of psychotherapy notes.

- To use your information for marketing purposes for which financial payment is received.
- For any sale involving your information resulting in financial or non financial payment.

Your Individual Rights:

You have certain rights regarding information that Health First creates, obtains or maintains about you. To exercise these rights, please contact us at the location below:
Health First
Health Information Management Department
3300 S. Fiske Blvd., Building B
Rockledge, FL 32955

Review or get a copy of your information

You can ask to see or get a copy of your information stored in paper or electronic records. We will provide a copy or a summary of your information. If there are records that we cannot share or if we need to limit access, we will inform you as to this fact. We may charge a fee to process your request.

Ask us to correct your information (Amendment)

You can ask us in writing to correct your information if you feel that it is incorrect or incomplete. We will correct the information if allowed by law. We may say "no" to your request, but we will explain the reason in writing. If your request is denied, you can ask us to keep a copy of your disagreement (a written statement you provide to us) with your records.

Ask us to limit what we use or share (Restriction)

You can ask us in writing not to use or share your information. We will always consider your request, but we may say "no" if it would affect our ability to provide care or service to you or cause a customer safety concern. If we agree to the restrictions, we will abide by them.

Request confidential communications

You can ask us in writing to contact you in a specific way or at a specific location (for example, home or office phone). We will not ask you the reason of your request and we will accommodate all reasonable requests.

For Health Plan customers: If you notify us that a possible communication could endanger you, we must accommodate your reasonable request for confidential communications.

Get a list of who has received your information (Accounting of Disclosures)

You can ask us for a list of the times we have shared your information with outside organizations or customers, who we shared it with, and why. Your request must be in writing and must include a specific time period.

We will include any disclosure that occurred within the last six years of your request, where we have shared your information, except for when it was about your treatment, payment for your treatment or health care operations. We will provide you with the date of disclosure, the name of the entity or person who received the information and a brief description of the information disclosed.

Get a copy of this notice

We reserve the right to change this notice. The changes will apply to all information we have about you. If we make any changes, we will post the new notice at all Health First locations and websites. We will provide a current copy to you upon enrollment, annually and when you receive services at any Health First entity. Health Plan customers, however, will receive this notice upon enrollment and no less frequently than once every three years. Unless you are a Health Plan customer, we are required to ask you to sign an acknowledgment that you have received this notice.

You can ask for a paper copy of this notice at any time even if you agreed to receive this notice electronically. We will provide it as requested.

We may provide this notice to you by email if you have agreed to receive electronic notification. We are required by law to follow the privacy notice that is in effect at this time. This notice is also available on our website at HF.org.

File a complaint if you feel your privacy rights have been violated

You can complain directly to us if you feel we have violated your privacy rights by contacting us using the information available at the end of this notice. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. Find contact information at *www.hhs.gov/ocr/privacy/hipaa/complaints*. We won't retaliate against you for making a complaint.

Your Choices

In some situations, you have additional choices about how we use and share your information. If you have a

preference in the situations described in this document, let us know. Tell us what you want us to do, and we will follow your instructions while following the law.

You can tell us not to:

Share your information with your family, close friends or others involved in your care or payment for your care.

You can also tell us not to share your information with others for health research (we can still use your information for our own research as long as we follow the law).

Our Responsibilities:

- We protect your information because your privacy is important to us, and because it is the law.
- We must follow the responsibilities and privacy practices described in this notice.
- We must make this notice available to you when you become a customer and must post it online at HF.org
- We will let you know in accordance with the law if a breach (unauthorized access, use or sharing) occurs that may have put the privacy of your information at risk.
- We will not use or share your information except as covered in this notice, unless you tell us we can in writing. You may revoke your authorization at any time. Let us know in writing if you change your mind.
- When the law requires us to get your permission in writing before we use or share your information, we will do so.
- We will not use your genetic information to decide whether we will give you coverage and the price of that coverage.

Health Information Exchange Opt-Out- Health First Medical Group, LLC and Health First Privia Medical Group, LLC ONLY

Health First Privia Medical Group, LLC participates in a Health Information Exchange ("HIE"). You have the right to opt out of disclosure of your medical records to or via an electronic health information exchange ("HIE"). However information that is sent to or via an HIE prior to processing your opt-out may continue to be maintained by and be accessible through the HIE. You must opt out of disclosures to or via an HIE through each of your individual treating providers who may participate in any given HIE. To opt out, you will need to fill out the Health First Privia Medical Group, LLC HIE Opt-Out Request Form ("Request Form") and/or contact the HIE directly. To receive a Request Form or for other information regarding the HIE, please contact your Health First Medical Group, LLC or Health First Privia Medical Group, LLC physician office. If you decide later on that you want to opt back into the HIE, you may do so by submitting the Health First Privia Medical Group, LLC Reinstatement of Participation Form ("Reinstatement Form"). To receive a Reinstatement Form, please contact your Health First Medical Group, LLC or Health First Privia Medical Group, LLC physician office.

In addition to contacting your physician office, if you have questions regarding the HIE or to receive the Request Form or the Reinstatement Form, you can email **privacy@priviahealth.com**. Additionally, to opt out of the HIE, please email **medicalrecords@priviahealth.com**.

For information, questions or complaints

You may get more information about our privacy practices and your privacy rights by calling Health First Chief Privacy Officer at **321.434.7543**. You can also find this information online at **HF.org**. You can also contact the Health First HIPAA and Compliance Hotline at **1.888.400.4512**.

Effective: April 1, 2003
Revised: July 2016, October 2019, January 2020

[1]Health First Privia Medical Group, LLC is a Limited Liability Company attached to the Health First, Inc. IDN but is owned by community physicians.

[2]For the purpose of this notice, Health First Health Plans, Inc., Health First Administrative Plans, Inc., Health First Commercial Plans, Inc., Health First Insurance, Inc., and AdventHealth Advantage Plans are herein referred to as "Health Plan."

Non-Discrimination Against Dual-Eligible Enrollees

Health First Health Plans Providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program. Health First Health Plans Providers shall not balance bill or collect Medicare Part A and Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program.

Annually each April, Provider Network Operations will review a listing of current QMB members and monitor the physician network by examining member complaints and correspondence from provider offices. Provider Network Operations will address any non-compliant Providers with Government Programs and determine what corrective action is needed, if any. Health First Health Plans reserves the right to periodically request payment records from provider offices for the purposes of auditing compliance in this area.

Section 10: Pharmacy

Formulary Administration

Health First Health Plans' formularies represent prescription therapies considered to be part of a quality treatment program. Our formularies are closed, which means we do not cover non-formulary drugs except when deemed medically necessary via PA approval. We may make negative changes to the formulary during the calendar year with approval from a Pharmacy and Therapeutics Committee and when the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market. If this happens, we will notify the affected members of the change within 60 days or as soon as we are notified, whichever happens first. We also make positive changes during the year, including reducing the quantity limit, removing PA requirements, and adding newly released generic medications.

All the formularies will identify if certain drugs require PA, Step Therapy or have a Quantity Limitation. When submitting a request for PA or to skip a step therapy or exceed the quantity limitation, we require that the office provide a supporting statement, applicable medical records and any labs that are required for us to make a medical necessity decision.

If your patient needs a medication that is not listed on their formulary, you may request that we cover it. This request must include the applicable medical records, required labs and a statement from the prescriber on why the drugs on the formulary would not be as effective, why they have failed or why the patient cannot take them due to adverse reactions. Your request must include all the drugs that have not been successful in treating the patient's condition. You can find our authorization forms on our public website: **myHFHP.org**.

Decision Timeliness

We make decisions to PA and formulary exception requests within timeframes that comply with regulatory and accreditation requirements.

Formulary PA and exception requests are typically completed within 72 hours* of receiving a complete request. A complete request should include a provider supporting statement, applicable medical records, and lab results.

*Our lines of business allow up to 14 days for this review. However, we have most requests completed within 72 hours.

If we do not receive a provider supporting statement, applicable medical records, and lab results, we will make three separate attempts to contact the requestor's office to remain compliant with the timeliness requirements. If we do not receive the information requested after the third attempt, we may deny the request.

Injectable, implantable, and infusible authorization requests are completed within three business days for all lines of business.

If waiting for a decision in the standard timeframe could seriously harm the patient's life, health, or ability to regain maximum function, you can request an expedited decision. This means we will make a decision for Medicare Advantage requests within 24 hours, and within 72 hours for Individual requests.

Consistency in Applying Criteria

We evaluate the consistency of PA requests and determinations by performing peer review and quality audits. Any opportunities for improvements and recommendations are reported to the Pharmacy and Therapeutics Committee and ultimately to the PAC.

Appropriate Professionals

The Medical Director supports our Managed Care and Clinical Pharmacists and assists with review of medical necessity for PA and exception requests.

Section 11: Compliance

As a Medicare Advantage and Prescription Drug Plan sponsor, Health First Health Plans, Inc. is mandated to establish a Compliance Program to prevent, detect and correct areas of noncompliance, including Fraud, Waste and Abuse (FWA). This program meets the regulatory requirements set forth in 42 CFR § 422.503(b)(4)(vi) and 423.504(b)(4)(vi). As a result, our efforts are focused on guidelines that reduce the risk of unlawful and unethical behavior.

Health First Health Plans (used in this section to refer jointly to Health First Health Plans, Inc., and Health First Administrative Plans, Inc.) maintains a Compliance Program which includes the Privacy Office, the Health Plans' Corporate Integrity (Compliance Department) and a Special Investigations Unit (SIU).

For this Compliance section, "Provider" includes any medical group, clinician, physician, medical services entity, or medical goods company that provides goods or services to any of our customers, members, covered persons or insured (herein referred to as members).

Provider Compliance Responsibilities

As a participating Provider, you are a partner in our commitment to conform with high ethical standards and compliance with all governing laws and regulations, not only in the delivery of healthcare, but in our business affairs, dealings with employees, physicians, members, and the communities we serve.

Providers contracted with us are required to abide by the applicable policies and procedures of Health First Health Plans and its related entities. This includes amendments and subsequent policies and procedures.

Providers shall adopt and implement our policies or create and implement policies which are significantly like those of Health First Health Plans, including, but not limited to the Health First Code of Ethics and Business Conduct, and the Health First policies on Privacy and Information Security, Compliance and Fraud, Waste and Abuse.

Providers shall maintain compliance with all applicable federal and state privacy and security laws.

Providers shall cooperate with all reviews, auditing, monitoring and follow-up monitoring by the Compliance and/or SIU Department(s) at no cost to Health First or its affiliated companies. This cooperation includes but is not limited to providing all requested documents and/or other information as we deem necessary.

Providers shall comply with billing, coding, service requirements and prohibitions as directed by Health First Health Plans. For provision of services to Medicare Members, Providers shall abide

by applicable Medicare requirements. As a condition of payment, Providers shall abide by all applicable state and federal laws, including applicable licensure laws, anti-kickback laws, self-referral laws, patient brokering laws, patient's rights laws, medical practice laws, coding/billing laws and Medicare requirements when providing goods or services to Medicare patients/members.

Providers shall also comply with the exclusions screening requirements set forth by Section 1862 of the Social Security Act. The Provider must ensure that employees and downstream entities are screened against the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities and the System for Award Management list prior to hiring or contracting, and monthly thereafter. Monthly screening must include all current employees, new employees, temporary employees, volunteers, contractors, and consultants to ensure individuals are not excluded or become excluded from participation in federal programs.

(This Compliance Program Overview includes summaries for some of the prominent statutes that apply for all participants with the Medicare and Medicaid programs and are provided below for review. These are not intended to be legal advice.)

Provider Reviews

The Integrity Department and/or SIU may periodically conduct reviews, audits or monitoring of providers. Health First monitors provider billing practices, conducts audits and reviews for purposes of detecting inappropriate, inaccurate, or abusive billing patterns, and monitoring the quality of patient care and proper licensing. The department also receives referrals of possible FWA from CMS, our members, providers, and internally through various departments. All leads are investigated.

If your practice receives notice requesting medical records or specific documents, please cooperate with the notice and any other instructions provided. If a Provider fails to respond to a request for documents and/or information pursuant to a review, monitoring or audit, the Provider shall be placed on prepayment or similar review until the issue is resolved. Such claims or similar claims will not be considered clean claims for the purpose of processing. As mandated by law, the SIU is responsible for recovery of funds improperly paid resulting from overpayments, fraud, abuse, errors, misrepresentation, or concealment of facts.

Providers shall allow the Health First Compliance and/or SIU staff to interview the Provider's staff, employees, contractors, owners, managers, management entity, agents, landlord, clinical personnel, billing staff/agent, service providers and other related persons. Providers shall allow the Health First Compliance and/or SIU staff to reasonably visit and access a Provider's locations and facilities. A Provider's failure to provide access to locations and facilities and/or the persons or entities listed above shall result in the Provider being placed on prepayment or similar review until the issue is resolved. Failure to cooperate or provide access will deem a claim as not clean for the purpose of processing. Additionally, the Provider shall have all related or similar claims deemed overpayments and any pending requests denied. Such Provider may also be subject to

peer review. We may notify members regarding a failure by a Provider to abide by the terms of this Provider Manual or the Provider Contract.

Compliance Program Elements

At Health First Health Plans we have implemented an effective Compliance Program which includes measures to prevent, detect and correct Part C and Part D program noncompliance and FWA. Our program contains the following core elements:

1. Written policies, procedures, and standards of conduct
2. A Compliance Officer, Compliance Committee, and high-level oversight
3. Effective training and education
4. Effective lines of communication
5. Well-publicized Disciplinary Standards
6. An effective system for routine monitoring, auditing, and identification of compliance risks
7. Procedures and a system for prompt response to compliance issues, and
8. Efforts to combat Fraud, Waste and Abuse

As a Provider, you are required to be an active participant in our Compliance Program. We have developed policies and procedures, in addition to the Health First Code of Ethics and Business Conduct, which define our organization's values and provide guidance in our commitment to ethical business practices. As a participating Provider, you are responsible to adopt and implement the Health First Code of Ethics and Business Conduct and applicable policies and procedures that comply with all applicable laws and regulations. Should you choose to create your own Code of Ethics and policies and procedures, they must be significantly like those of Health First and comply with all applicable laws and regulations.

Compliance Attestation

On or before September 30th of each calendar year, providers must complete and return the Health First Health Plans Medicare FDR Compliance Program Statement of Attestation form in accordance with the Health Plans First Tier, Downstream and Related Entity Oversight Policy and its corresponding procedures. The Corporate Integrity Department can be reached for questions about the attestation form at Integrity@HF.org**.** The form confirms a provider's agreement to comply with applicable requirements related to record retention, privacy, and security, contracting with downstream entities and non-United States/offshore subcontractors, exclusion screenings, disciplinary actions, reporting non-compliance, and notification and correction of identified deficiencies.

Contact Information

There are several avenues to report noncompliance, including FWA concerns, to Health First's Corporate Integrity Department. We encourage you to use the communication method with which

you feel most comfortable. We enforce a strict zero-tolerance policy for retaliation or intimidation against any individual who reports suspected noncompliance and/or FWA in good faith.

Health First Health Plans' Care Team

Entity	**Telephone Number**
AdventHealth Advantage Plans	844.522.5278
Health First Health Plans	844.522.5282
TTY	800.955.8771

Health First Chief Compliance Officer/Chief Integrity Officer and Privacy Officer

The System Vice President, Associate General Counsel, Chief Privacy Officer may be reached at: Integrity@HF.org

Health First Compliance Hotline

The Compliance Hotline can be used to report ethical, compliance, HIPAA, privacy, and FWA concerns 24 hours a day, seven days a week at: 888.400.4512. (Caller may remain anonymous.)

Fraud, Waste, and Abuse (FWA)

Overview

Health First Health Plans takes FWA very seriously. Our SIU is tasked with the detection, prevention, and investigation of FWA in the delivery of healthcare services.

FWA are improper actions that result in inappropriate and unnecessary spending. Fraud is distinguished from waste or abuse in that it is committed when one knowingly or willfully makes a material misrepresentation or omission with the intent to defraud and obtain a benefit. Waste refers to overutilization, extravagant, careless, or needless expenditure of healthcare benefits or services often caused by disorganization or a misuse of resources. Abuse describes practices that are inconsistent, or outside the bounds of generally accepted practices in the industry, which result in unnecessary services and payment.

Detection

Several sources are used for detection as well as proactive and reactive processes to detect FWA, including but not limited to hotline reports, internal employee escalation, external industry sources, pre-payment and post-payment claim review, claim edits, and data analysis. Any report, regardless of source, may result in an investigation.

Prevention and Investigation

As part of its prevention and investigative efforts, our SIU may initiate investigations which may include but are not limited to an audit of a provider's records. Prepayment review may be applied to the claims of a Provider or Member for whom there is a basis to suggest inappropriate billing or services may be occurring. Post-payment review may be conducted when there is a basis to suggest inappropriate billing or services relating to a Provider or Member after claims have previously been processed and paid.

Pre and post-pay claims payment reviews entail a thorough review of submitted claims, and review of available, and when needed requested information, to determine whether the data submitted on the claim is accurately and appropriately supported. At times these reviews may be conducted at the provider's location. Information requested or reviewed onsite may include but is not limited to medical records, billing statements, evidence of member cost share collection, invoices, administration records, test results, nursing notes, audit logs, providers orders, lab requisitions, certificates of medical necessity as well as the medical record documentation that supports each of these. Providers are responsible to ensure that their available documentation fully supports the data, and medical necessity of the procedures, services, and supplies, submitted on the claim. This includes, but is not limited to, compliance with the most stringent medical record documentation standards that would apply, and Medicare's Medical Record Documentation standards in the absence of others, as well as compliance with national coding and billing standards (i.e., CPT®, HCPCS, ICD-10). These reviews may result in full denial of the claim or specific claim lines if documentation is insufficient or does not substantiate data submitted. Records that contain cloned documentation, conflicting information or other such irregularities may be disallowed for reimbursement.

Additionally, a post-payment review may involve a sampling and extrapolation methodology, where allowed, or may require the Provider to cooperate in the performance of a self-audit to resolve identified issues. Investigations may involve review of contemporaneous treatment records as well as interviews with associated parties including members and providers.

Resolution

Based on the findings of an investigation, SIU may pursue corrective actions including but not limited to provider placement or continuation on pre-payment review, provider education, recovery of overpaid funds including claims offsets, repayment demands, legal action, termination of contract, and reporting to state and federal regulators and/or law enforcement.

Reporting Fraud, Waste, and Abuse

If providers or provider organizations suspect potential FWA in any form, they must report it immediately. To report, you can contact the SIU in the following ways:

- Compliance Hotline: 888.400.4512
- Portal: **hf.ethicspoint.com**

- Email: **Integrity@HF.org**
- Mail: **Health First Health Plans**
  Special Investigations Unit
  6450 US Highway 1
  Rockledge, FL 32955

Please call the Compliance Hotline at 888.400.4512 with any general compliance-related concerns (including reporting violations of law, regulations, policies, or procedures) and questions about our Compliance Program, or to seek advice about how to handle compliance-related situations at work. All calls are treated confidentially, and callers can remain anonymous if they so choose. Callers may be asked whether they are willing to identify themselves so that an issue may be followed up with the caller after the call ends. Reports through the Compliance Hotline may remain anonymous. Retaliation against anyone who raises a concern is prohibited.

While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information also can be found liable under the False Claims Act.

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. The False Claims Act also imposes liability on an individual who may knowingly submit a false record to obtain payment from the government. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records to retain the money.

The civil provisions of the False Claims Act make a person liable to pay damages to the government if he or she knowingly:

- Conspires to violate the False Claims Act
- Carries out other acts to obtain property from the Government by misrepresentation
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

For more information, refer to 31 United States Code (U.S.C.) §§ 3729-3733.

Health Care Fraud Statute

The Health Care Fraud Statute states that "Whoever knowingly and willfully executes, or attempts to execute, a scheme to defraud any health care benefit program … shall be fined … or imprisoned not more than 10 years, or both."

Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law. *For more information, refer to 18 U.S.C. §1347.*

Anti-Kickback Statute

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a federal healthcare program (including Medicare).

For more information, refer to 42 U.S.C. §1320a-7b(b).

Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest, or
- A compensation arrangement (exceptions apply)

The term "referral" means "the request by a physician for the item or service" for Medicare Part B services and "the request or establishment of a plan of care by a physician which includes the provision of the designated health service" (DHS) for all other services. DHS includes "clinical laboratory services"; "physical therapy services"; "occupational therapy services"; "radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services"; "radiation therapy services and supplies"; "durable medical equipment and supplies"; "parenteral and enteral nutrients, equipment, and supplies"; "prosthetics, orthotics, and prosthetic devices and supplies"; "home health services"; "outpatient prescription drugs"; "inpatient and outpatient hospital services"; and "outpatient speech-language pathology services." A "financial relationship" includes ownership, investment interest and compensation arrangements. Certain exceptions exist for specific situations.

For more information, refer to 42 U.S.C. §1395nn.

Health Insurance Portability and Accountability Act (HIPAA)

Florida Statutes § 501.171. Florida Information Protection Act

Health Insurance Portability and Accountability Act 45 C.F.R. Parts 160 and 164 Standards for Privacy and Security of Individually Identifiable Health Information; Final Rule; August 14, 2002.

Omnibus Rule Modification, January 2013.

For more information, refer to hhs.gov/hipaa/for-professionals/index.html

Compliance Hotline

1.888.400.4512

Privacy | Compliance | Fraud, Waste and Abuse

The Hotline is open for you 24/7 to report suspected compliance concerns. Reports can be made **anonymously** and there is a **no retaliation policy** when concerns are made in **good faith**.

Visit HF.org