Provider Manual
Section 4.0
Office Standards

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4.0 Office Standards

PCPs are required to provide coverage for Lighthouse enrollees twenty-four (24) hours a day, seven (7) days a week. When a PCP is unavailable to provide services, the PCP must ensure that he or she has coverage from another participating provider. Hospital emergency rooms or urgent care centers are not substitutes for coverage from another participating provider. Participating providers can consult their Lighthouse Provider Directory or contact Provider Services at 844-243-5181 with questions regarding which providers participate in the Lighthouse network.

4.1 Appointment Scheduling Standards

Providers must adhere to the following appointment scheduling standards to assure timely access to medical care as required AHCA. Compliance with these standards will be audited by periodic on-site review of provider offices and chart sampling.

Appointment Type	**Access Standard**
PCPs – Well Care Visit/ Non-Urgent Adult and Pediatric Well Care Visit	Within thirty (30) calendar days
PCPs – Urgent	Within forty-eight (48) hours of request for medical or behavioral health care services that do not require prior authorization Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization
PCPs –Sick Visit – Specialist Non-Urgent - Ancillary Service – diagnosis/treatment of injury, illness, or other health condition	Within one (1) week Within sixty (60) calendar days Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition
Behavioral Health – Routine visits Behavioral Health – Non-Urgent Behavioral Health – Post discharge from an Inpatient Admission Behavioral Health – Initial outpatient behavioral health treatment	Within ten (10) calendar days Within thirty (30) calendar days Within seven (7) calendar days post discharge Within fourteen (14) calendar days or ten (10) business days

Behavioral Health-Urgent	Within forty-eight (48) hours of request for medical or behavioral health care services that do not require prior authorization Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization
Behavioral Health – Sick Visit	Within one (1) week
Behavioral Health Non-Life-Threatening Emergency	Within six (6) hours
Emergency Providers	Immediately; twenty-four (24) hours a day, seven (7) days a week and without prior authorization

4.2 Enrollee to Provider Ratio Maximum

The provider enrollee-to-PCP ratio is not to exceed 3,000:1. If any PCP is concerned about his or her panel size or prefers a ratio smaller than 3,000 to 1, he or she should notify Provider Network Management in writing at the following address:

Lighthouse Health
PO BOX 211156
Eagan, MN 55121
Attention: Provider Network Management

By default, Lighthouse sets the maximum panel size at 3,000 enrollees per provider. However, the ratio may be adjusted for practices that employ physician extenders, such as physician assistants. Lighthouse will consider exceptions to the 3,000:1 ratio upon PCP request. Exceptions will be allowed based on an analysis of the practice capacity and on the geographic availability of other PCP practices contracted with Lighthouse.

For additional information regarding requests for panel closings and limitations, please see Section 2.8.4.

4.3 Provider Office Standards

Providers must not differentiate or discriminate in the treatment of any enrollee because of the enrollee's race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.

The office waiting times should not exceed forty-five (45) minutes. Enrollees should be scheduled at the rate of six (6) or less per hour.
Health assessments/general physicals should be scheduled within thirty (30) days.

EPSDT screens for any new enrollee younger than twenty-one (21) years of age should be

scheduled within thirty (30) days of enrollment, unless the child is already under the care of a PCP and the child is current with screens and immunizations.

EPSDT screens for any new enrollee younger than two (2) years of age should be scheduled within an appropriate time frame so that the child is not out of compliance with any required screenings.

PCPs should have a “no show” follow-up policy. For example, the PCP or specialist might mail two notices of missed appointments to the enrollee, then follow-up with a telephone call to the enrollee. Any follow-up actions for missed appointments should be documented in the enrollee’s medical record.

Enrollee medical records must be maintained in an area that is only accessible to persons employed by the practice. When releasing an enrollee’s medical record to another practice or provider, providers are required to first obtain written consent from the enrollee.

Any provider’s office administering care that may have an adverse effect on the enrollee must obtain the enrollee’s signature on a form that describes the treatment, as well as the medical indication and the possible adverse effects.

Providers must complete specific treatment consent forms, such as hospice, sterilization, hysterectomy, or abortion as required by state and federal regulations and laws.

4.4 Medical Record Keeping, Continuity, and Coordination of Care Standards

Lighthouse has adopted the following medical record keeping standards, which cover confidentiality, organization, documentation, access, and availability of records. These standards are determined by the **National Committee for Quality Assurance (NCQA)** and AHCA, and they may be revised as needed to conform to new NCQA or AHCA recommendations. Compliance with these standards may be audited by periodic on-site review of providers' offices and chart samplings. Providers must achieve an average score of eighty percent (80%) or higher on the medical records review. Lighthouse will monitor providers’ scoring less than eighty percent (80%) through corrective action plans and re-evaluation.

4.4.1 Confidentiality of Records

Providers are also required to have policies that address privacy and confidentiality of enrollee information. Those policies shall be compliant with all state and federal laws including, but not limited to:

- Compliance to ensure the confidentiality of medical/case records in accordance with 42 CFR Part 431, Subpart F;
- Compliance with Health Insurance Portability and Accountability Act (HIPPA) policies and procedures. (Policies and procedures shall be easily accessible for all staff enrollees.);
- Ensure that medical records are NOT accessible to those not employed by the

practice;

- Post notice of privacy practices (NPP) in a prominent area of the office;
- Ensure that HIPAA policies and procedures are easily accessible for all staff enrollees;
- Provide disclosures of PHI, patient's right to request restriction of the use of PHI, and include a contact person within the practice;
- Locate copier and fax machines in an area that restricts unauthorized access or viewing;
- Password protect all computer screen savers;
- Protect all staff enrollees' computer access by requiring unique log-ins and time-limited passwords;
- Ensure that office staff mark PHI emails as secured or encrypted; and
- The Lighthouse enrollee or authorized representative shall sign and date a release form before any clinical/case records can be released to another party. Clinical/case records release shall occur consistent with state and federal law.

4.4.2 Organization of Records

- There is only one medical record per patient;
- The medical record is bound, or it has fastened pages to prevent loss of medical information;
- Every page in the record contains the enrollee's name or ID number;
- The medical record is organized in chronological order with the most up-to- date information appearing first. The record includes separate sections for progress notes, lab results, x-ray and other imaging studies, hospital records (ER report and discharge summaries), home health nursing reports, physical therapy reports, etc.; and
- All charts contain flow sheets for health maintenance.

4.4.3 Documentation

- The record is legible;
- Personal data includes date of birth, age, height, gender, home and work addresses, employer, home and work telephone numbers, marital status, emergency contact information, school name and telephone numbers (if no phone contact name and number), race, ethnicity, guardianship/custodial arrangements, and preferred language;
- Entries are done in smudge-proof non-erasable ink;
- Medication allergies, adverse reactions, and no known allergies are prominently noted in the record;
- There is a completed immunization record in all pediatric records and/or appropriate history in all adult records;
- All charts contain a problem list, a medication list, and a treatment plan. Significant illnesses and medical conditions are indicated on the problem list, including working

diagnoses;

- Medical history (for enrollees seen three or more times) is easily identified and includes medical, surgical, obstetric histories, and serious accidents. For children and adolescents (18 years of age and younger), medical history includes prenatal care, birth, operations, and childhood illnesses;
- At each visit, documentation includes height, weight, BMI for adults 20 years of age and older and BMI percentile for enrollees age 20 and under;
- All entries in the medical record are signed or initialed and dated and all providers are identified by name;
- Encounter forms or notes have a notation, when indicated, regarding follow- up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed;
- Documentation will reflect assessment of and counseling for tobacco, alcohol, substance abuse, and risk of sexually transmitted diseases;
- If a consultation is requested, there is a note from the consultant in the record;
- Consultation, lab, and x-ray reports filed in the chart are initialed by the provider to indicate review. Consultation and abnormal lab and imaging study results have a specific notation in the record of follow-up plans;
- Emergency care provided is documented in the medical record, as well as follow-up visits provided secondary to reports of emergency room care;
- Evidence of reportable diseases and conditions are documented and reported appropriately to local or state health departments;
- There is evidence that preventive screenings and services are offered in accordance with Lighthouse's Clinical Practice Guidelines. Use of risk assessments, disease maintenance, and preventive health sheets are encouraged (see Section 16, "Forms and Documents" for samples);
- Copies of consent forms, when applicable, are maintained in the record;
- The medical record also contains an indication of whether an adult (over eighteen (18) years old) enrollee has executed an advance directive and a copy of the enrollee's advance directive, as applicable;
- Written denials for service and the reason for the denial are documented in the medical record; and
- Hospital discharge summaries are included in the medical record; medication reconciliation to be performed within 30-days post-discharge for enrollees 18 years of age and older.

4.4.4 Advance Directive

All medical/case records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) and whether or not the enrollee

has executed an advance directive. Neither Lighthouse, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or to waive an advance directive.

4.4.5 Access and Availability of Records

Lighthouse shall follow the medical/case record standards set forth below for each enrollee's medical/case records, as appropriate:

- Include the enrollee's identifying information, including name, enrollee identification number, date of birth, sex, and legal guardianship (if any);
- Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications;
- Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services, and services for the treatment of sexually transmitted diseases;
- Document referral services in enrollees' medical/case records;
- Each record shall be legible and maintained in detail;
- An immunization history;
- The enrollee's use of tobacco, alcohol, and drugs/substances;
- Summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up;
- The primary language spoken by the enrollee and any translation needs of the enrollee;
- The enrollee's need for communication assistance in the delivery of health care services;
- All entries shall be dated and signed by the appropriate party;
- All entries shall indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider;
- All entries shall indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports;
- All entries shall indicate therapies administered and prescribed;
- All entries shall include the name and the profession of the provider who rendered the services (e.g., MD, DO, OD), including the signature or initials of the provider;
- All entries shall include the disposition, recommendations, and instructions to the enrollee, and include evidence of whether there was a follow-up and the outcome of services; and
- Copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13) years.

4.4.6 Continuity and Coordination of Care

While there are some indicators of continuity and coordination of care included within the documentation standards, Lighthouse will also assess medical records for evidence of continuity and coordination of care using the following criteria:

- The record is legible to someone other than the writer (Any record determined illegible by one reviewer shall be evaluated by a second reviewer);
- At each office visit, the history and the physical performed are documented and reflect appropriate subjective and objective information for presenting complaints, including any relevant psychological and social conditions affecting the patient's medical/behavioral health;
- The working diagnosis is consistent with the clinical findings;
- The plan of action and treatment is consistent with the diagnosis, and it includes medication history and medications prescribed, which includes the strength, amount, directions for use, as well as any therapies or other prescribed regimen;
- Lab and other studies are ordered as appropriate;
- Unresolved problems, referrals, and results from diagnostic tests, including results and/or status of preventive screening services (EPSDT) from previous office visits are addressed in subsequent visits;
- There is a review for the under-and over-utilization of consultations;
- Age or disease-appropriate direct access services or referrals, including: immunizations, diabetic retinal eye exams, family planning, and cancer screening services;
- There is no evidence that the patient is placed at an inappropriate risk by a diagnostic or therapeutic problem; and
- Follow-up plans include consultations, referrals, directions, and time to return.

4.5 Hospital Care

Providers must have admitting privileges to a Lighthouse network hospital or facility for all patient groups for whom they are providing care to. A provider may arrange for another participating provider to provide inpatient coverage.

4.6 Florida Health Information Exchange (FHIE)

Lighthouse is dedicated to improving the health and quality of life of our enrollees and actively supports the statewide implementation of the **Florida Health Information Exchange (FHIE)**. The FHIE is the secure electronic information infrastructure created by AHCA for sharing health information among health care organizations, and

it offers health care providers the functionality to support meaningful use and a high level of patient-centered care.

Lighthouse encourages participating PCPs to connect to the FHIE through various communication channels, such as annual workshops, routine onsite visits, and general provider relations interaction.

FHIE is a secure, interoperable network that participating providers with certified **electronic health record (EHR)** technology can use to locate and share needed patient information with each other, which results in improved coordination of care among physician practices, hospitals,

labs, and across the various health systems. Some of the benefits include:

- Real time access to patient health information, including:
- Detailed patient summary
- Rx/medication history
- Laboratory results
- Radiology and other transcribed reports
- Clinical reminders/alerts
- Improved patient care quality and safety
- Reduced health care costs by reducing duplication of care
- Improved efforts to reduce health disparities
- Informed medical decisions at the time/place of care

The Office of Health Information Exchange and Policy Analysis produces statutorily mandated reports, administers the Medicaid Electronic Health Record (EHR) Incentive Program, provides governance of the Florida Health Information Exchange (HIE), and provides research and analytic support to AHCA.

The Florida Health Information Network website provides information and resources relating to AHCA's initiatives for Health Information Technology (HIT) and Health Information Exchange (HIE): www.fhin.net

Details about services, the latest news and events relating to the Florida HIE initiative, and information on becoming a participant can be found at: www.florida- hie.net

Information about the Medicaid Electronic Health Record Incentive Program can be found at http://ahca.myflorida.com/Medicaid/EHR/index.shtml.

Reports produced by this Office can be found on the Research Studies and Reports page on FloridaHealthFinder.gov: http://www.floridahealthfinder.gov/researchers/studies-reports.aspx.

4.7 Communication Guidelines

AHCA has developed guidance related to both enrollee materials and for other communication for providers who participate in Medicaid MCOs in the state. The guidance includes the following:

Marketing in the Health Care Setting

1. The Managed Care Plan shall not conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

2. The Managed Care Plan shall not conduct marketing in areas where patients primarily intend

to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

Provider-Based Activities

1. If the Managed Care Plan chooses to utilize its provider network to distribute marketing materials, the Managed Care Plan shall ensure through its provider agreements that providers shall remain neutral.

2. The Managed Care Plan may permit providers to make available and/or distribute Managed Care Plan marketing materials as long as the provider does so for all Managed Care Plans with which the provider participates.

3. The Managed Care Plan may permit providers to display posters or other materials in common areas, such as the provider's waiting room.

4. The Managed Care Plan may permit LTC facilities to provide materials in admission packets announcing all Managed Care Plan contractual relationships.

5. The Managed Care Plan may not permit providers to:

    a. Offer marketing/appointment forms.

    b. Make phone calls or direct, urge, or attempt to persuade potential enrollees to enroll in the Managed Care Plan based on financial or any other interests of the provider.

    c. Mail marketing materials on behalf of the Managed Care Plan.

    d. Offer anything of value to persuade potential enrollees to select them as their provider or to enroll in a particular Managed Care Plan.

    e. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.

6. Provider Affiliation Information

    a. Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).

    b. Providers may make new affiliation announcements within the first thirty (30) days of the new provider agreement.

    c. Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.

d. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider has agreements.

7. Materials that indicate the provider has an affiliation with certain Managed Care Plans and that only list Managed Care Plan names, logos, product taglines, telephone contact numbers, and/or websites do not require Agency approval.