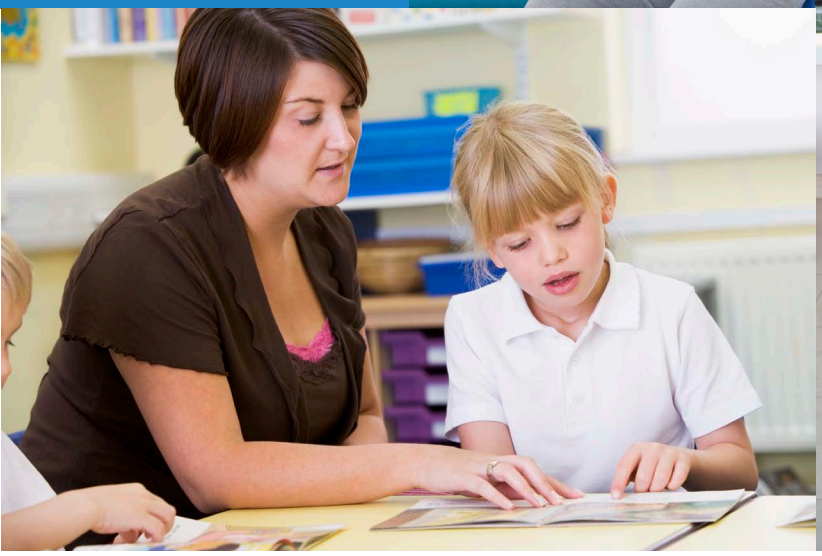

2016/2017

AMERIGROUP HEALTH PLAN SPECIFIC INFORMATION

American Therapy Administrators of Florida

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Address:

2001 South Andrews Ave

Ft. Lauderdale , FL 33316

Toll Free:

(888) 550-8800

Fax:

(855) 410-0121

AmeriGroup

Authorization Process

ATA-FL can receive an authorization request via facsimile at (855) 410-0121.

UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage/care nor does it encourage decisions that result in underutilization.

Authorizing Services - Amerigroup (Medicaid and Healthy Kids)

Initial Authorization of post-evaluation, subsequent visits: Based on the information provided, visits for Medicaid and Healthy Kids members subsequent to the evaluation (noted as "subsequent visits" in your contract reimbursement section) will be authorized based on Category as follows (methodology for assigning Categories and visits authorized, may change as determined by ATA-FL.

Medicaid and Healthy Kids

Category 1 (3 visits): most acute and shorter-term diagnoses

Category 2 (9 visits): chronic and longer term diagnoses, developmental delays over 1 year

An authorization number will be provided which can be used as a reference for the entire episode of care. The initial authorization period for the subsequent visits will be given for duration of 3 months or 6 months from the date of the evaluation. The initial authorization period for subsequent visits is valid until the last authorized visit, or the end of the authorized period, whichever comes first.

Reimbursement for any authorized visit will be the same regardless of the time spent with the Member by the treating provider for that particular visit. In addition, authorized visits shown do not include the evaluation and are not intended to be a limit on compensated care but is the next step in the authorization process.

Authorization of Extended Episode Fees (EEF): Therapy services will be authorized after submission of the Patient Intake form as described in this manual. An authorization does not need to be obtained prior to performing an initial Therapy evaluation on a member but will need to be obtained prior to submitting claims for performing any additional Therapy service and/or in order to be reimbursed for any Therapy services provided, including the initial evaluation. Claims submitted prior to obtaining an authorization will be denied.

After completion of initial approved number of subsequent visits within the initial authorization period, additional therapy will

Authorization Process (cont'd)

be approved if required in the Plan of Care and if provided, will be compensated through an Extended Episode Fee (EEF) or otherwise based on the contractual terms of your provider services agreement with ATA-FL. For obtaining EEF assignment, please secure authorization for additional medically necessary covered services by submitting an updated Patient Intake Form with the following information:

- Number of visits scheduled, number of visits completed and date of last visit
- Any changes/updates from the original Patient Intake Form: diagnosis, patient deficits, school treatment information, etc… should be noted in the section provided under **"Additional information"**

Based on this information, an EEF level will be assigned. After the evaluation, the EEF Level is paid and processed once a claim for services within the authorization period of the EEF Level is received. For example, on a Category 1 case the provider will complete the evaluation, then three subsequent visits. An EEF level is then assigned after submission of the Patient Intake form. An EEF level is paid and processed upon submission of a claim for the first visit during the EEF authorization period. The EEF is payment for all eligible services provided during the term of the authorization period.

You will receive confirmation via fax from ATA-FL of the assigned Extended Episode Fee (EEF) after submitting the updated Patient Intake form.

Duration of EEF: For medically necessary services that are authorized for six months, an additional EEF level may be paid under most circumstances. If you have provided services continuously for four months after the evaluation, then update the Patient Intake form where indicated and submit for consideration for another EEF payment (the additional EEF payment would be payable upon the submission of the claim for the first date of service occurring more than four months after the evaluation).

Authorizing Services — Amerigroup (Medicare LOB)

For Therapy services provided to Amerigroup Medicare members, services are assigned an Extended Episode Fee (EEF) Level for each episode of care which includes all services rendered within the authorization period for that Level. Post-Evaluation, subsequent visits are not issued for Medicare members. After the evaluation, the EEF Level is paid and processed once a claim for services within the authorization period of the EEF Level issued is received. EEF Levels are paid in addition to any member copayments.

Assignment Of Levels & Upgrades

Assignment Of Extended Episode Fee (EEF)

The assignment of Extended Episode Fees (EEF) are based on diagnosis, intensity of services normally required for patients with like characteristics, and patient service utilization and circumstances to date. The information provided in the Patient Intake form, along with your update after completing authorized subsequent visits (for Medicaid and Healthy Kids only), will determine the level. In general, EEF levels are assigned as follows:

Medicaid and Healthy Kids

Level 1 Mild diagnoses
Level 2 More moderate diagnoses
Level 3 Most Category 3 cases, with moderate treatment requirements
Level 4 Category 3 cases requiring more intensive treatment
Level 5 Catastrophic Cases

Medicare

Level 1 Level 1: Mild diagnoses including miscellaneous pain, extremity strains and sprains
Level 2 Mild to moderate diagnoses including most fractures, spinal sprains
Level 3 Moderate to more severe; most shoulder issues other than joint pain; most post-operative
Level 4 Very severe; knee replacement post-operative within 30 days
Level 5 Catastrophic Cases

Upgrade Requests of EEF Level or Duration:

There may be instances when higher EEF levels than originally assigned may be justified due to special complicating factors requiring more intensive treatment relative to the basic diagnosis or, in other cases, ATA-FL may have based the EEF level decision on inaccurate or incomplete information received. A review process that could result in increasing the EEF level or shortening of the EEF is available through the upgrade process.

Requests for upgrades of the assigned level or change in the duration covered by the Extended Episode Fee can be made by noting the nature of the request on the cover of your fax (i.e. “please upgrade from Level 2 to 3”)

Assignment Of Levels & Upgrades (cont'd)

or mailed documents, and faxing/mailing in the most recent evaluation and progress notes. This information will be reviewed by an ATA-FL Clinical Consultant. It is important that the evaluation and progress notes follow appropriate standards for documentation, including:

- Patient deficits in strength, range of motion, etc. expressed objectively
- Specific treatment goals defined objectively (with timeframe to achieve goal)
- Relevant factors included (i.e., date of surgery, other services provided in school, etc.)
- For developmental delay cases, actual measurements/delay using a standardized assessment tool and documentation of any improvement achieved in therapy

After ATA-FL has made an upgrade determination regarding EEF level that is assigned, a peer to peer consultation may be requested by a provider. If, after a provider has had the opportunity to discuss the EEF level with the ATA-FL clinical consultant, the provider is not in agreement with the level issued, ATA-FL will submit a denial notification to the provider and the member, which will include the provider and member appeal process.

Claims & Reimbursement

Our preferred method of claims submission is through our Clearinghouse. **Our Clearinghouse vendor is Emdeon. Our Payer ID is 65062 for professional claims and 12k89 for institutional claims.** It will be necessary for a provider to submit their electronic claim encounters to ATA-FL via this Payer ID. **Emdeon will notify the providers if their electronic claims were accepted or if claims were rejected. Providers may contact Emdeon directly for submittal details.**

If you still prefer to submit via paper, please send CMS 1500 forms or other approved billing forms (i.e. UB-92) to:

American Therapy Administrators of Florida
Claims Processing Center
P.O. Box 350590
Fort Lauderdale, FL 33335-0590

Providers may also use the HN1/HS1 Web Portal (www.healthsystemone.com) to submit claims. The Web Portal provides your office the ability to check status of your submitted claims 24/7 regardless of the method of submission (paper, electronic, Web Portal entry). If you wish to sign up, please send an email to webmaster@healthsystemone.com and we will contact you to set-up your account.

For status of claims, please call Claims Customer Services at 877-372-1273. Please listen carefully to the voice prompts.

Please note that for ATA-FL claims for Amerigroup members, Providers are **NOT** to be utilizing the ATA-FL Web Portal. Providers using the ATA-FL Web Portal for submitting claims for Amerigroup members may result in claims not getting processed correctly or timely. All ATA-FL Amerigroup claims should be sent to the P.O. Box or Emdeon address listed in this section or entered directly to the HN1/HS1 Web Portal (www.healthsystemone.com).

Do not send any claims to the health plan. Payments inadvertently made to your practice by the health plan for members assigned to ATA-FL are overpayments and have to be returned to them.

Services are reimbursed as described in Attachment A and/or the applicable Payor's Plan Addendum of your contract. Any Extended Episode Fee payments cover all services provided over a period of time and, therefore, will cover multiple dates of service. However, **it is still necessary for a claim to be submitted for each date of service for a patient.** Submittal of all claims allows ATA-FL to meet data reporting responsibilities to

Claims & Reimbursement (cont'd)

the health plan, enables ATA-FL to give you accurate reports and profiles, and provides ATA-FL with information we need for internal monitoring and review. **Please note that failure to submit all claims data may also impact a provider's compensation under their ATA-FL agreement.** To meet timely filing requirements, claims submitted for payment must be received within 3 months of the date of service. The allowable amount will be reduced by 50%, as noted in your contract, for claims received more than 3 months but less than six months from the date of service. Payment for all other claims received beyond 6 months from the date of service shall be deemed waived.

Extended Episode Fees are fixed rates over a period of time for all necessary and appropriate treatment, which is inclusive of the number and duration of the visits. Patients are entitled to all covered medically necessary care under the Extended Episode Fee, as determined by the treating therapist in consultation with the referring physician's office. ATA-FL does not dictate or specify exact treatment requirements or visit limitations. It is expected that the therapist will provide appropriate care, delivered efficiently and with the necessary patient (or parent/caregiver, as applicable) education to allow the patient to meet their goals from activities both in a clinical setting and during their activities of daily living outside of the clinic. If the therapist feels at any time during the patient's treatment that the Extended Episode Fee does not adequately compensate them for the therapy services needed, the therapist should contact ATA-FL and request an Upgrade as outlined in this manual. The therapist must at all times provide the appropriate care they have determined is needed in the patient's plan of care.

Timing Of Claims Payment:

Our Claims Department processes claims as they are received. ATA-FL of Florida strictly adheres to state and federal claims processing guidelines for Medicaid and Medicare lines of business.

Please refer to the Health Plan issued member ID card to find co-payment information or you may obtain the co-payment information when verifying eligibility with Amerigroup directly. Please refer to the member ID card for the phone number of Amerigroup's eligibility department.

Co-Payments & Eligibility

Durable Medical Equipment, Orthotics and Prosthetics, other specialized services: refer the member back to the Health Plan.

Other Services & Providers

Under the Amerigroup ATA-FL agreement, ATA-FL serves as the mandatory Therapy (PT/OT/ST) outpatient network for all Amerigroup Florida members

All claims related to outpatient therapy services provided to Amerigroup's Florida members should be sent directly to ATA-FL for processing and payment.

Covered Members