AMERICAN THERAPY ADMINISTRATORS OF FLORIDA

PROVIDER PRESENTATION UPDATE

Enhanced Utilization Management Model

Physical Therapy, Speech Therapy and Occupational Therapy

12/18/17

Provider Training Tool Publication

Enhanced Utilization Management Model at ATA-FL

Why are we improving our model now?

- We want providers to submit all visit encounters as required by state and federal agencies, so we are linking subsequent level payments to the submission of all visit encounters. This is already required/complied with by provider under a FFS model.
- We want to reduce administrative burden for our provider network from multiple submissions of similar documentation to one submission per episode of care.
- We want to remain compliant with AHCA requirements.
- We want to introduce new evidence-based criteria in our UM process.

What is Changing?

- **NEW** As we continue to improve our UM model, we have recently adopted use of standardized test scores in conjunction with Milliman Care Guidelines to authorize levels of service.
- **NEW** Using the submitted diagnosis, the results of standardized test scores, Milliman Care Guidelines, and the clinical record, ATA-FL will authorize levels of service. In the authorization process we will provide you with "reasonable" or "expected" ranges in the number of visits that correspond to the payment level. The provider may proceed with more visits than the "reasonable" or "expected" number contained within our authorization letter; however, actual visits should align with the Plan of Care.
- **NEW** The manner of payment under the new model is a pure case rate model. We will cease issuing an initial number of subsequent visits at a FFS rate. The evaluation will no longer be paid separately. The evaluation will fall under the first level assignment along with all of the other DOS as set forth in the plan of care in the first 60 days of the certification period.
- The Management of therapy services at ATA-FL via a case rate model will not change. This means that levels are assigned and payment is based on those levels.
- **NEW** Each of these levels will correspond to a range of visits.
- After the evaluation, an authorization must be obtained from ATA-FL before treatment begins and you will not be paid for services prior to this date. You do not need to request authorization to complete the evaluation. However, remember that all services rendered , including an evaluation only, must have a certification number in order for the claims to process. The evaluation will no longer be paid separately.

Milliman Care Guidelines(MCG)

- Nationally recognized and widely used clinical guidelines.
- Provides observed ranges of visits based upon diagnosis
- Eight of the ten largest U.S. health plans use Milliman Care Guidelines.
- Improves healthcare effectiveness with evidence-based care guidelines.
- MCG's clinical editors analyze and classify peer-reviewed research in support of the guidelines.
- Annually more that 140,000 references are reviewed.

Issuance of a Level

Upon receipt of the authorization request an ATA-FL clinician will review the request and issue a Level based upon the diagnosis, Standardized Test Scores, MCG and clinical record.

- **Level 1 –** Evaluation only/within normal limits
- **Level 2 –** Mild impairment level
- **Level 3 –** Moderate impairment level
- **Level 4 –** Severe impairment level
- **Level 5 –** Profound impairment level

Tertiary, Medically Complex patients are covered by the health plan. Our UM team will assist providers in referring any patients identified as such to the health plan for appropriate authorization and services.

Using test scores to assign levels Speech Therapy examples:

ATA-FL reviews the diagnosis, results of standardized test scores, MCG and clinical record, and assigns a level.

Test Name	Abbrv.	Test Score Type	Level 5	Level 4	Level 3	Level 2	Level 1
Level of Impairment			Profound	Severe	Moderate	Mild	WNL
Goldman Fristoe Test of Articulation	GFTA-2 GTTA-3	Std Score Std Score	≤64 ≤64	65-70 65-70	71-77 71-77	78-84 78-84	85-100 85-100
Preschool Language Scale English/Spanish	PLS4-E/S PLS5-E/S	Std Score Std Score	≤64 ≤64	65-70 65-70	71-77 71-77	78-84 78-84	85-100 85-100
Clinical Assessment of Articulation and Phonology	CAAP CAAP2	Std Score Std Score	≤64 ≤64	65-70 65-70	71-77 71-77	78-84 78-84	85-100 85-100
Test of Auditory Processing Skills-3rd Ed.	TAPS3	Std Score Percentile	≤60 ≤0.4	60-69 0.4-1.9	70-79 2-8	80-89 9-24	90-110 25-75

Requesting an Authorization: 4 Critical Elements

All treating providers MUST submit the following 4 Critical Elements with the authorization request. Providers may submit via the Provider Web Portal @ ataflorida.com/hs1portal or via fax to ATA-FL at 1-855-410-0121.

1. Prescription or Referral Form
2. A completed ATA-FL Intake Form (N/A to Providers using the Provider Web Portal) including 3 attestations
3. POC with diagnosis signed/dated by the referring physician and/or Letter of Medical Necessity (LMN)
    i. The Plan of Care must include the evaluation and the start and stop dates
    ii. The Plan of Care must include the Signature of the referring physician recorded on or after the recorded date of the treating therapist
    iii. The therapist that develops the POC must sign and date the document on the date it is completed. The therapist must sign and date the POC prior to the PCP's signature and date. The PCP may sign and date the POC on the same date the therapist signs and dates the POC.
4. Standardized Assessment Scores clearly denoted

- CRITICALLY IMPORTANT: **If any of the above elements are missing, ATA-FL will not approve the authorization request. Based on ATA-FL delegated responsibilities, the case will either be denied by ATA-FL or referred to the health plan with recommendation for denial.**
- **Failure to provide all required documentation could result in the delay of treatment of your patient. Retrospective requests will not be authorized.**

Plan of Care Documentation

- **ATA-FL will not accept ranges from providers when indicating the following in the Plan of Care: number of visits, the duration of the visit, or the duration of the treatment.**
- Acceptable examples
  - 2 visits per week
  - 30 mins per visit
  - 6 weeks of treatment
- Unacceptable examples
  - 1 – 2 visits per week
  - 30 mins – 60 mins per visit
  - 4 – 6 weeks of treatment

Case Scenarios

- When an ATA-FL clinician identifies a significant deviation in the Plan of Care from the range in number of visits according to the diagnosis, standardized test scores, Millman Clinical Guidelines and clinical record reviewed, the provider will be contacted.
- Outcomes of Peer to Peer

  A. Approved - If after Peer to Peer, clinician agrees with Plan of Care, authorization is provided.

  B. Provider agrees to withdraw current request and resubmit with documentation to support medical necessity.

  C. Provider chooses NOT to withdraw the current request. Provider refuses to accept the level issued. Case is referred to the Medical Director. If the Medical Director is in agreement with the clinician, and based on ATA-FL delegated responsibilities, the case will either be denied by ATA-FL or referred to the health plan with recommendation for denial.

Request for an Upgrade of an Existing Authorization

- ATA-FL will only issue authorizations for upgrades when a change in diagnosis or a change in test scores is submitted. (In rare clinical circumstances upgrades may be authorized without a change in either diagnosis or test scores.)
- Upgrades will not be authorized retrospectively (after the treatment period).
- The provider must submit the Upgrade request via fax to ATA-FL at 877-583-6440.
- The Upgrade Request must include the following:
  - The completed ATA-FL Upgrade Request Form
  - New POC, **signed/dated by the referring physician**, in addition to the original Plan of Care.
  - **Change in Standardized Test Scores or**
  - **Change in Medical Diagnosis**
  - Documented patient progress in metrics/quantitative data

Review Process for an Upgrade Request

ATA-FL will submit the Upgrade request to a clinician (a licensed therapist in the same discipline) for review.

If Approved:

- ATA-FL will modify the existing authorization to a higher level.
- The provider will receive the authorization via facsimile with the Certification Number referencing the higher level.

If Not Approved:

- If medical necessity is not established based on the information received, a peer-to-peer consultation with a clinician is offered to the treating provider.
- If after the peer-to-peer, a decision cannot be agreed upon, the request for an upgrade will be submitted to the Medical Director for review.

If the Medical Director is in agreement with the clinician, based on ATA-FL delegated responsibilities, the case will either be denied by ATA-FL or referred to the health plan with recommendation for denial.

How will we notify the treating provider of an authorization?

- Via the Provider Web Portal at ataflorida.com/hs1portal/
- In addition, ATA-FL will fax the treating provider an authorization indicating the Level and the authorization period.
- Expedited/Urgent Requests are completed within 24 hours for Medicaid members.
- Authorization Requests Received without the 4 Critical Elements (Slide 7) will not be approved and will be referred to the health plan with recommendation for denial.

An expedited/urgent request is only warranted when applying the standard time (7 days) for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function.

Requesting a New Authorization After the Authorization Period Has Ended

If a member requires further therapy after the authorization period has expired, the provider may request another authorization, following the steps below:

A. Perform a re-evaluation of the patient to create a new POC with diagnosis signed/dated by the referring physician.

B. Request an authorization via the Provider Web Portal at ataflorida.com/hs1portal/ or via fax to ATA-FL at 1-855-410-0121 .

C. Submit the **4 Critical Elements** as stated on Slide 7 including the re-evaluation **and the following 5th item**

   Documented patient progress in metrics/quantitative data in the form of a progress **Report**, which demonstrates the patient's progress to date. The Report must include comprehensive quantitative data regarding ALL goals targeted for the previous authorization period as established in the POC.

Upon receipt of the information listed above, ATA-FL will review the submitted documentation. ATA-FL will issue a new authorization as indicated and a new authorization period begins.

Requesting Authorizations for Multiple Therapy Disciplines

A. If a patient requires treatment for more than one type of therapy during the same treatment period, such as both Occupational *and* Speech Therapy, follow the steps outlined below:
   1. Request two separate authorizations via the Provider Web Portal at ataflorida.com/hs1portal/ or via fax to ATA-FL at 1-855-410-0121.
   2. All documentation requirements, including the *4 Critical Elements* as outlined in Slide 7 must be included for both disciplines with each request.
   3. All requests of this kind, for more than one therapy discipline, will be submitted to Clinicians for the review of medical necessity.

B. ATA-FL does not issue a separate episode level for symptoms or conditions associated with the main diagnosis. For example, for a therapy request for Status Post Total Knee Replacement, ATA-FL assigns a level according to date of surgery. Concurrent requests for pain, including back pain, gait, instability, muscle weakness, etc.; would be considered related to the main diagnosis, and ATA-FL will not issue a separate level.

Payment of Levels for Developmental Delay

Payment of Levels for Developmental Delay may result in a maximum of three (3) Level payments during the episode of care (180 days).

- After receipt of the first claim encounter after issuance of the level by ATA-FL the first case rate will be paid to the rendering provider.
- After receipt of the claims encounters during the initial sixty day period and after receipt of the first claim encounter following day 60 of the 180 day authorization period the second case rate will be paid. Payment of levels will be contingent upon the performance of services and receipt of encounters consistent with the Plan of Care.
- After receipt of the claims encounters during the second sixty day period and after receipt of the first claim encounter following day 120 of the 180 day authorization period the third case rate will be paid. Payment of levels will be contingent upon the performance of services and receipt of encounters consistent with the Plan of Care.

Payment of Levels when Upgrade is Approved for Developmental Delay

- If at any time during the 180 day treatment period the provider requests an Upgrade and ATA-FL increases the level assigned, the current level AND all subsequent levels will be paid at the higher level during the 180 day treatment period.
- Upgrades may not be applied retrospectively (after the 180 day treatment period has ended).

Payment of Levels for Non-Developmental Delay

- After receipt of the first claim encounter after issuance of the level by ATA-FL the case rate will be paid to the rendering provider.

Payment of Levels when Upgrade is Approved for Non-Developmental Delay

- If ATA-FL approves an upgrade, the current level assigned will be increased.
- The level increase will be paid after receipt of the next claim encounter within the 60 day treatment period.
- Upgrades may not be applied retrospectively (after the 60 day treatment period has ended).

Provider Relations Territory Distribution

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Region 3 Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
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Region 6 Hardee, Highlands, Hillsborough, Manatee, and Polk
Region 7 Brevard, Orange, Osceola, and Seminole
Region 9 Indian River, Martin, Okeechobee, and St. Lucie

Important ATA-FL Contact Numbers

Department	Name	Title	Toll-Free Telephone and Fax	Email
Provider Relations	Jessica Quintana	Network Director	T 305-614-0100 Ext 4202 F 305-614-0369	QuintanaJ@healthnetworkone.com
Provider Relations	Lazara Cruz	Provider Relations Representative	T 888-550-8800 Option 2 F 305-620-5973	CruzL@healthnetworkone.com
Provider Relations	Luis Martinez	Provider Relations Representative	T 888-550-8800 Option 2 F 305-620-5973	MartinezL@healthsystemone.com
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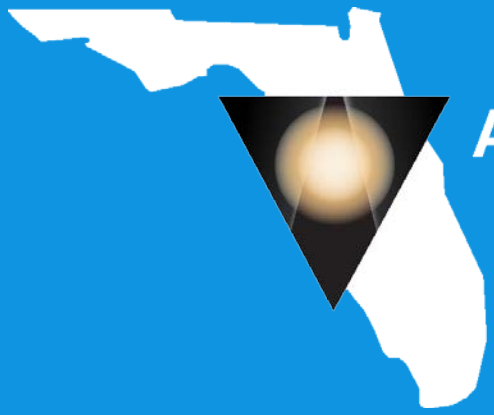
Referrals/ Authorizations	Milagros Rodriguez	Team Leader	T 888-550-8800 Option 1 F 855-410-0121	RodriguezM@healthsystemone.com



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