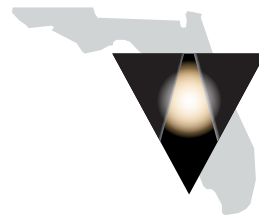




2016/2017

SUNSHINE 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) 980-2380

ATA-FL can receive an authorization request via facsimile at (800) 980-2380.

Authorizing Services- Sunshine Health (Medicaid and Child Welfare)

Initial Authorization of post-evaluation, subsequent visits: Based on the information provided, visits for Medicaid and Child Welfare 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 Child Welfare

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 be approved if required in the Plan of Care and if provided, will be compensated through an Extended Episode Fee or otherwise based

Authorization Process (cont'd)

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 Extended Episode Fee 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).

Assignment Of Levels & Upgrades

Assignment Of Extended Episode Fee (EEF)

The assignment of Extended Episode Fees 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, will determine the level. In general, extended episode fee levels are assigned as follows:

Medicaid and Child Welfare

- 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

Upgrade Requests of EEF Level or duration:

There may be instances when a higher EEF level 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 is available to ATA-FL providers 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") 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:

Assignment Of Levels & Upgrades (cont'd)

- 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, if necessary, 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 recommendation for denial to the health plan for final determination.

Claims & Reimbursement

The preferred method of claims submission is through our Web Portal. The Web Portal also provides the Provider's office the ability to check status of your submitted claims 24/7. If the Provider wishes to sign up for this service please send an email to atafli@therapyadmin.com and we will contact you to set up an account. Most providers using this method find it very quick and easy to use and it speeds up the payment to the provider.

If your office prefers to submit claims electronically, please be advised that we are now receiving claims through our vendor Emdeon. **Our Payer ID is 65064 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.**

As a Provider 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 21607
Ft. Lauderdale, FL 33335-1607**

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

Do not send any claims to the health plan.

Payments inadvertently made to the Provider's 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 Health 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 the health plan and regulatory entities, enables ATA-FL to give the Provider accurate reports and profiles,

Claims & Reimbursement (cont'd)

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, and is grounds for cause termination under the 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 strictly adheres to state and federal claims processing guidelines for Medicaid and Medicare lines of business.

Co-Payments & Eligibility

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 Sunshine Health directly. Please refer to the member ID card for the phone number of Sunshine's eligibility department.

Other Services & Providers

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

Covered Members

Under the Sunshine Health ATA-FL agreement, ATA-FL serves as the mandatory Therapy (PT/OT/ST) outpatient network for all Sunshine Health **Medicaid** members in Regions 3, 4, 5, 6, 7, 8, 9, 10 and 11.

Under the Sunshine Health ATA-FL agreement, ATA-FL serves as the mandatory Therapy (PT/OT/ST) outpatient network for all Sunshine Health **Child Welfare** members in Regions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11.

All claims related to outpatient therapy services provided to Sunshine's Florida **Medicaid & Child Welfare** members should be sent directly to ATA-FL for processing and payment.