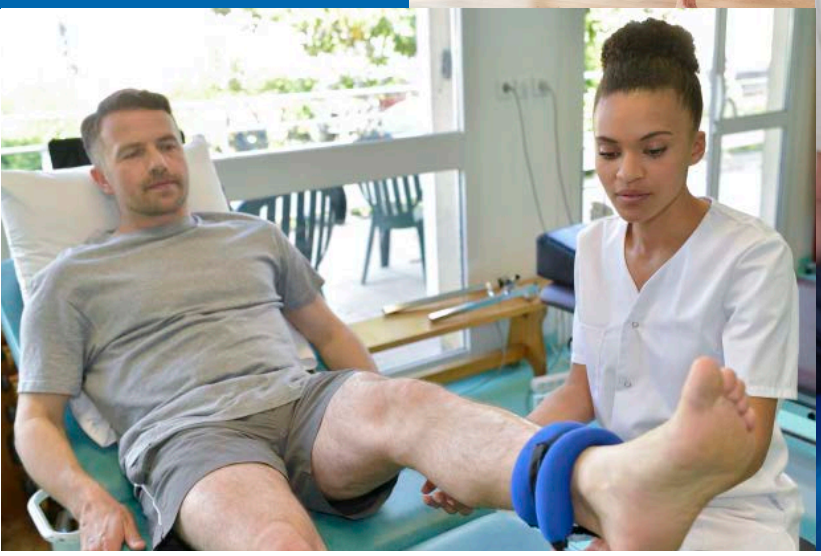


2020
Provider Reference Manual

Community Care Plan Medicaid and Healthy Kids

AMERICAN THERAPY
ADMINISTRATORS OF FLORIDA

Community*care*
the health plan with a heart
PLAN

TABLE OF CONTENTS

ADDRESS:

2001 South Andrews Ave

Ft. Lauderdale, FL 33316

TOLL FREE:

(888) 550-8800

FAX:

(305) 620-5973

AUTHORIZING SERVICES

MEDICAID (ALL AGES) & HEALTHY KIDS

Service Exclusions

Dual enrolled members, Tertiary cases, Scholastic School based Therapy, Hospital Inpatient Therapy, Home Health, Partial Day Rehabilitation, Spinal Cord Injuries, PPEC, Non-traditional free-standing rehabilitation Therapy services including but not limited to hippo therapy, art therapy, music therapy, vision therapy, aquatic therapy, ABA and cognitive therapy are not covered by ATA-FL. Our UM team will assist providers in referring any patients identified as such to the health plan for appropriate authorization and services.

All rendering providers MUST submit the following Three Critical Elements with the authorization request. Providers must submit via the Provider Web Portal at ataflorida.com/hs1portal/. However, fax is available as an emergency back up via ATA-FL fax at **1-855-410-0121**.

1. Prescription or Referral Form (N/A for re-evaluations)

   - Evaluation;
   - New POC/evaluation must be signed by the treating Therapist;
   - Expired POC from the certification period that just ended must be signed by the treating Therapist and referring provider (physician/ARNP/P.A.).

2. POC with diagnosis signed/dated by the referring provider (physician/ARNP/P.A.) and/or Letter of Medical Necessity (LMN)

   - The Plan of Care must include the evaluation and the start and stop dates
   - The Plan of Care must include the Signature of the referring provider (physician/ARNP/P.A.) recorded on or after the recorded date of the treating therapist
   - 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.

3. Assessment Scores clearly denoted

CRITICALLY IMPORTANT: If any of the above elements are missing, ATA-FL will not be able to approve the authorization request. Based on ATA-FL's delegated responsibilities, the case will be 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.

Provider notification of authorization:

- Via the Provider Web Portal at https://www.ataflorida.com/hs1portal
- In addition, ATA-FL will fax the treating provider an authorization indicating the Level and the authorization period.
- Routine requests are completed within **7 days**.
- Expedited/Urgent requests are completed within 24 hours.
  - 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.
- Authorization requests received without the 4 Critical Elements will be 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 provider (physician/ARNP/P.A.), in addition to the original Plan of Care.
- Change in Standardized Test Scores or
- Change in Medical Diagnosis
- Progress notes/daily notes from the last **3** visits
- Documented patient progress in metrics/quantitative data
- List all of the rendered DOS on the Upgrade Request Form

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.

A. 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.

B. 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 be referred to the health plan with recommendation for denial.

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 treating Therapist signature.

- New POC/evaluation must be signed by the treating Therapist.
- Expired POC from the certification period that just ended must be signed by the treating Therapist and referring provider (physician/ARNP/P.A.).

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 page **3** including the re-evaluation and the following **5TH** item

D. 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:

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 must be included for each discipline 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.

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.

Requesting Authorizations for Custom Hand Splints:

All treating providers MUST submit the Patient Splint Form. The form is located on the ATA-FL website www.ataflorida.com under provider resources. Providers must submit the form via fax to ATA-FL at **1-855-410-0121**. Upon receipt of the authorization request an ATA-FL clinician will review the request and issue a Level.

PEER TO PEER

You may request a Peer to Peer with our reviewing clinician if you do not agree with the level assigned in the authorization. The Peer to Peer must be requested within the same certification period.

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 be referred to the health plan with recommendation for denial.

LEVEL ASSIGNMENTS

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. The levels are:

- 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;

Dual enrolled members, Tertiary cases, School based Therapy, Hospital based and/or Inpatient Therapy, Home Health, Partial Day Rehabilitation, Spinal Cord Injuries, Non-traditional free-standing rehabilitation Therapy services including but not limited to hippo therapy, art therapy, music therapy, vision therapy, aquatic therapy, ABA and cognitive therapy is covered by the health plan. Our UM team can assist providers in referring any patients identified as such to the health plan for appropriate authorization and services.

IMPAIRMENT LEVELS

1
Evaluation Only
(within normal limits)

2
Mild

3
Moderate

4
Severe

5
Profound

DOCUMENTATION

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**

Referring practitioner's signature must include their NPI, Credentials and Date of Signature

IMPORTANT:

All practitioner's signature must include their NPI, Credentials and date of signature as defined in Chapter 668, Part I, F.S. Please ensure that the referring provider's (physician/ARNP/P.A.) LMN, Prescription or Referral Form includes their NPI, Credentials and date of signature.

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, Milliman Clinical Guidelines and clinical record reviewed, the provider will be contacted.

Documentation Tips

- Pertinent medical history, not just the treatment Diagnosis;
- Prior level of function, if applicable;
- Baseline information that is related to the goals;
- Level of overall impairment and severity of impairment;
- Specific level of skills for areas of concern;
- Short / Long term goals (Measurable and Functional);
- Updated goals as needed to demonstrate progress;
- Specific Frequency and Duration;
- Approved abbreviations;
- Is your document legible?;
- Did you document why there were missed visits or why goals were not achieved?;
- Does the therapist signature include their NPI, Credentials and Date of Signature?

REIMBURSEMENT

Case rate 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 and provides ATA-FL with information we need for internal monitoring and review.

Medicaid and Healthy Kids-Developmental Delay

Providers are required to submit claim encounters for all services rendered, each and every visit and service are to be reported in the form of a claim to ATA-FL. This claim encounter ensures that the Plan's members are receiving therapy services as authorized by ATA-FL per the POC. ATA-FL uses this claim data, to pay claims to our providers, monitor adherence to the POC, but also to submit as encounters to our health plan partners. Our health plans are required to submit this same encounter data to the state's Medicaid and Healthy Kids program. The state uses the encounter data to review and ensure that therapy services are delivered to the Plan's Medicaid members.

Payment of Levels:

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 claim 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 claim 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.

ATA-FL will apply a payment rule for Developmental Delay cases. Additional payments during the episode of care will be issued based on the provider's compliance with the approved POC and ATA/FL's receipt of claim encounters. ATA-FL is also adding minimum visit requirements. You may still receive one payment per span, for a maximum of three (**3**) payments, but in order to receive payment for a particular span, there must be service date claim encounters submitted within that span. The payment amount and the assignment of levels remains the same; however, we are applying a minimum visit threshold. If the minimum visit thresholds are not met, based upon the claim encounters received, you will not receive the subsequent level payments during each of the **60** day spans.

The payment(s) of the approved levels during the episode of care will be issued as follows:

1. Three (**3**) payments may be issued per episode of care.
2. One (**1**) payment may be issued for each **60** day span in an episode of care.
3. Receipt of the first claim for services rendered during an episode of care will trigger the first payment.
4. The second span payment will be triggered once the minimum number of service visits is met, and no other payment has been issued for services in the second span. If there is no service visit in span **2**, no payment will be made.

5. The third span payment will be triggered once the minimum number of service visits is met, and no other payment has been issued for services in the third span. If there is no service visit in span **3**, no payment will be made.

6. Please refer to the grid below for the minimum number of service visits required:

Assigned Impairment Level	Minimum Required Visit For First Payment	Minimum Required Visits from Evaluation Date for Second Payment with at least one visit occurring in the Second or Third Span	Minimum Required Visits from Evaluation Date for Third Payment
LEVEL 2	**1**	**6**	**11**
LEVEL 3	**1**	**9**	**17**
LEVEL 4	**1**	**11**	**21**
LEVEL 5	**1**	**13**	**25**

Payment of Levels when Upgrade is approved:

- 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** or **180** day treatment period has ended).

Reimbursement for Custom Hand Splints:

Reimbursement for Custom Hand Splints will require written authorization from ATA-FL and will be reimbursed according to **Exhibit 1** of your Amendment and Plan Addendum.

CLAIMS

Case rate 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 and provides ATA-FL with information we need for internal monitoring and review.

Claim Submission:

The preferred method of claims submission is through our Web Portal. Providers may use the HN1/HS1Web 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 visit ataflorida.com/pwp to register for an account.

If your office prefers to submit claims electronically, please be advised that we are now receiving claims through our vendor Emdeon a.k.a Change Healthcare. 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.

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 350590
Ft. Lauderdale, FL 33335-0590

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

Claims Payment Adjustment:

All Medicaid and Healthy Kids providers of ATA-FL have **365** days from the date of the EOP/EOB to request an adjustment for a processed claim. However, ATA-FL reserves the right to consider all requests received after the **365** days has expired. For your convenience you may call a Claims representative at **1-877-372-1273** to inquire about your processed claims and/ or to request a claims adjustment.

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.

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.

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 Healthy Kids lines of business.

Provider Claim Complaint:

HN1 processes provider complaints concerning claims issues in accordance with **s. 641.3155, F.S**. HN1 allow providers ninety (**90**) days from the date of final determination of the primary payer to file a written complaint for claims issues. HN1 resolves all claims complaints within ninety (**90**) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (**3**) business days of resolution.

PATIENT RESPONSIBILITY

Providers may confirm co-pays details through Community Care Plan's website at **https://www.ccpcares.org.**

MEMBER SERVICES

ATA-FL is not delegated member services. If members have questions or concerns regarding their eligibility, benefits or out of pocket costs, please have them call the Health Plan telephone number located on the back of their Health Plan Member ID card.

CONTINUITY OF CARE

Medicaid and Healthy Kids

Continuation of Care (COC) period is up to **60** days from the date that the member switched to Community Care Plan Medicaid from another MMA plan or from the date that the member switched to Community Care Plan Healthy Kids from another Healthy Kids plan. The COC period ends when the old auth expires or when the **60** days ends; whichever comes first. You are not required to obtain an authorization from ATA-FL to continue providing these services during the Continuation of Care Period. If you are NOT a participating provider with HN1/ATA-FL, please refer the member to their Primary Care Physician or ordering Physician so that they may refer the member to a participating therapist. Members may also contact the health plan to locate a participating therapist. ATA-FL allows plan members to continue receiving medically necessary services from a not-for-cause terminated provider and processes provider claims for services rendered to such enrollees until the enrollees select another provider, for up to sixty (**60**) days after the termination of the provider's contract or until the member is able to locate a new provider, whichever comes first. Notwithstanding the provisions in this Section, a terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

FRAUD, WASTE, AND ABUSE AND COMPLIANCE TRAINING

This supplemental training is intended to provide you with the methods for reporting Compliance, Ethics, and Fraud Waste and Abuse violations (suspected or confirmed).

To complete the training please visit our website: **https://ataflorida.com/training** and select the ATA-FL FWA & Compliance training. At the end of the training you will be required to attest that you have completed the training.

To complete the training please visit our website: **https://ataflorida.com/training** and select the ATA-FL FWA & Compliance training. At the end of the training you will be required to attest that you have completed the training.

You can report these violations to ATA of Florida directly, the Federal Government, or to the affected Health Plan(s). You can also file your report anonymously.

The methods for reporting to ATA of Florida and the affected Health Plan(s) are listed below.

Hotline
(866) 321-5550 (Toll-Free)

E-MAIL your report to:
SIU@healthsystemone.com

MAIL your report to:
Special Investigative Unit
2001 S. Andrews Avenue
Fort Lauderdale, FL 33316

FAX your report to:
Attention:
Special Investigative Unit
(866) 276-3667

CREDENTIALING, DEMOGRAPHIC CHANGES OR PROVIDER TERMINATION

PROVIDER AND ALL THERAPISTS

Provider and all therapists employed by and/or associated with provider, including covering therapists, must meet all credentialing and re-credentialing requirements as may be established by ATA-FL.

Note: Please notify us when you employ new therapists so that they may be credentialed. They may not render services to Community Care Plan members until they have been fully credentialed.

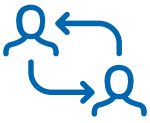
PROVIDER THERAPIST PERMANENT LICENSE

Provider must notify ATA-FL immediately when provider's provisional license number has been replaced by a permanent license.

FACILITIES AND ALL FACILITY LOCATIONS

Facilities and all facility locations associated with provider shall meet all credentialing and re-credentialing requirements as may be established by ATA-FL.

Note: Please notify us prior to opening a new facility or when relocating an existing facility so that ATA-FL can credential the new location. You may not render services to Community Care Plan members until the location has been fully credentialed.



DEMOGRAPHIC CHANGES OR PROVIDER TERMINATION REQUIREMENTS

Participating practices are required to notify ATA-FL immediately when:

- A Therapist employee has been terminated or is no longer treating patients at a specific location**
- A location is closing or relocating
- Demographic information is changing

** The Provider Service Agreement states, you are required to notify ATA-FL of any terminations 90 days prior to the termination. Non-Participating providers shall not evaluate, re-evaluate or treat beneficiaries managed by ATA-FL until they are credentialed by ATA-FL.

WHO IS MY ATA-FL PROVIDER REP?

If you have any questions about this information, changes to your practice, including demographic or provider additions/terminations, please notify your ATA of Florida Provider Relations Representative at: **1.888.550.8800**

Regions 6 and 8

Ana L. Ríos — Provider Relations Representative
Cell: (954) 955-0738
Office: (305) 614-0100 Ext. 4604
Fax: (305) 620-5973
Email: RiosA@HealthNetworkOne.com

Regions 10 and 11

Luis Martinez — Provider Relations Representative
Cell: (786) 681-9840
Office: (305) 614-0100 Ext 4223
Fax: (305) 620-5973
Email: MartinezL@HealthNetworkOne.com

Regions 1, 2, 3 and 5

Rosanna Briggs — Provider Relations Representative
Cell: (386) 898-1151
Office: (305) 614-0100 Ext 4215
Fax: (305) 620-5973
Email: BriggsR@HealthNetworkOne.com

Regions 4, 7 and 9

Paula Powell — Provider Relations Representative
Office: (305) 614-0100 Ext 4711
Fax: (305) 620-5973
Email: PowellP@HealthNetworkOne.com