ATA of Florida
2016 Q1

Provider Newsletter

MMA Managed Medical Assistance Member Express Enrollment

The State received approval of an amendment to Florida's 1115 MMA Managed Medical Assistance waiver to allow for Express Enrollment beginning January 2016.

MMA Waiver Amendment – Overview
Under Express Enrollment, the state will:

- Give recipients the opportunity to make a plan choice concurrent with eligibility application; and
- Assign Medicaid-eligible individuals who are mandated to participate in the MMA program to a health plan immediately after eligibility determination.

Express enrollment does NOT impact the LTC Program. Under the previous system, new Medicaid recipients had to wait 30-60 days before they could enroll in a health plan. Express Enrollment will NOW allow new enrollees who are mandated to participate in the MMA program to immediately take advantage of robust provider networks and access standards, and expanded benefits offered by the plan.

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Rehabilitative VS Therapy Services In The Schools

What is the difference between rehabilitative services with medical necessity and those provided in schools? Reimbursement for rehabilitation services through Medicaid cannot be duplicated by other providers and must show medical necessity for specific treatment(s) of a medical disorder, impairment, or disease. School rehabilitative services are school-based services, and educational goals are primary. Comprehensive documentation for rehabilitation services is required for Medicaid reimbursement, other requirements varies per school district and state.

Therapy services in schools are funded by state, local, and federal dollars, and based on learning abilities and educational outcomes i.e. IEP's. An educator or parent refers the child for a formal assessment after the child completes classroom interventions, and observations. The assessment must demonstrate a deficiency and it becomes part of the IEP. The primary indicator of eligibility is based on the child's ability to learn and gain skills during the school-aged years.

For Rehabilitative services, the physician refers the patient for a medical problem where therapy goals, developmental milestones, and functional outcomes are monitored. Therapy services are determined by standardized assessments and clinical observations, and funded by private sources, insurance, and other third party payers.

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Rehabilitative VS Therapy Services In The Schools

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CMS defines Medical Necessity as "a service that is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member". The service must be consistent with the symptoms of the illness or injury, be provided within generally acceptable professional medical standards, not performed for the convenience of the patient or physician, and furnished at a safe level and in a setting appropriate to the patient's medical needs. Some insurers and health plans further define medical necessity, in addition to Medicare's definition, as services that prevent, diagnose, or treat conditions, illness, and injury; that are not part of scholastic or vocational training; and are not investigational (National Institute for Health Care Management, 1995; and Blue Cross Blue Shield Federal Employees Health Benefit, from Appeals Made Easy, 2001).

The challenge for clinician's is the balance between demonstrating Medical Necessity while providing quality of care. For health plans, and the school system cost savings is essential while providing its members with the services they need.

3 STEPS

For a Successful Upgrade Process

SUNSHINE (MMA AND CHILD WELFARE), AMERIGROUP (MMA, HK AND MEDICARE), COVENTRY (MMA AND HK) AND HUMANA (MMA AND MEDICARE)

1. Completed upgrade form
2. Along with the Upgrade form please submit the most recent Evaluation or the most recent Re-Evaluation (whichever is most current)
3. Along with the Upgrade form and the Evaluation, please include the last three progress notes (keep in mind these notes must be able to paint a picture for the clinician who is reviewing the case. The therapist needs to be able to see progress or regression in the documentation; if the last three notes do not adequately reflect this, include additional notes that reflect the patient's deficiencies in order to aide us in making a proper level assignment based on the member's needs).

NOTE: Additional information may be requested if what has already been submitted does not adequately support the Medical Necessity for an additional upgrade. This may include requesting additional progress notes, or listing the dates of service that have already been rendered to confirm adherence to the POC.

Test Score Completion on the Intake form for Physical Therapists & Occupational Therapists

Although **Physical and Occupational Therapy** may not include a "Standard Deviation Score" in their evaluation process, each specialty does have an assessment and evaluation tool utilized to determine the patient's therapeutic needs. It is imperative that you include at least one test and outcome on the intake form; this will avoid delays in approvals. We must be able to determine the patient's needs in order to issue approval for Steps 1-3 on the Intake Form.

Timed Obstacle Ambulation Test — Insert Score Here — Include Age if applicable to test

Test Score	Test Used	Test Results (Standard Deviation)	Test Result (Age Equivalency)	☐ Month ☐ Year
Note/Comments:				

If the test does not calculate a score, please briefly describe the test results here.

Important: If the test and the outcome are not listed on the form, the Utilization Department will return the form to the provider via fax for completion. The approval will not be issued until the form is received with the missing information completed.

Quick Reference Guide for HS1 & Wonderbox Provider Portal

Effective 12/01/2015, claims and referral administration for Sunshine Health Plan's MMA and Child Welfare (CW) products and Coventry/Aetna Health Plan's Commercial/ Medicare and Medicaid/Healthy Kids (HK) products will be migrating to two separate platforms.

As of 12/01/2015 the Medicaid products for Sunshine Health Plan and the Medicaid and Healthy Kids products for Coventry Health Plan will be managed by Health System One. Health System One is currently managing the claims and referral administration processes for Humana and Amerigroup Health Plan products.

This will not change. As of 12/01/2015 Medicare and Commercial products for Coventry/Aetna Health Plan will only be managed by WonderBox Technologies.

As a reminder ATA-FL manages therapy services for all regions for Sunshine Health Plan's MMA and Child Welfare members and ATA-FL manages therapy services for Regions 1, 2, 3, 5, 6, 7 and Okeechobee and Indian River counties in Region 9 for Coventry Health Plan.

Department	Amerigroup, Humana, Sunshine & Coventry (HK/Medicaid)	Aetna & Coventry (Commercial & Medicare)
Provider Relations	888-550-8800 Option 2	
Provider Relations Fax	305-620-5973	
Authorization	888-550-8800 Option 1	888-560-6855
Authorization Fax	855-410-0121	888-560-6855
Claims	877-372-1273 Option 6	888-560-6855 Option 2
Electronic Claims Submission (EDI)	Direct Data Entry (DDE) through the HS1 Web Portal, or through the Clearinghouse, Emdeon, using: Professional Payer ID: 65062 Institutional Payer ID: 12k89	Direct Data Entry (DDE) through the WonderBox Provider Web Portal, or through the Clearinghouse, Smartdata Solutions, using: Professional Payer ID: ATHAL
Electronic Remittance Advice (ERA)	ERA provided via Emdeon. Provider must complete Emdeon ERA Provider Setup	You can obtain a hard copy of your EOB via the ATA Wonderbox Web Portal.
Paper Claims Submission	P.O. Box 350590 Fort Lauderdale, FL 33335-0590	P.O. Box 511 Milwaukee, WI 53201
Electronic Funds Transfer (EFT)	Initial payment sent via VPay with options for EFT or check available by calling: 855-388-8374 (Vpay EOB's will be sent via Fax to Providers)	Use form EFT Authorization and fax it to 866-231-6344, or to: Email it: crolejniczak@therapyadmin.com
Web Portal Access Requests	Administered by Health System One (HS1). Please complete the online form at: http://ataflorida.com/pwp/	Administered by WonderBox Technologies. To request access please send an email request to: atafledi@therapyadmin.com
Provider Web Portals	http://www.ataflorida.com/HS1webportal/	http://www.ataflorida.com/wonderbox/

April Jung

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Yeslin Marcos

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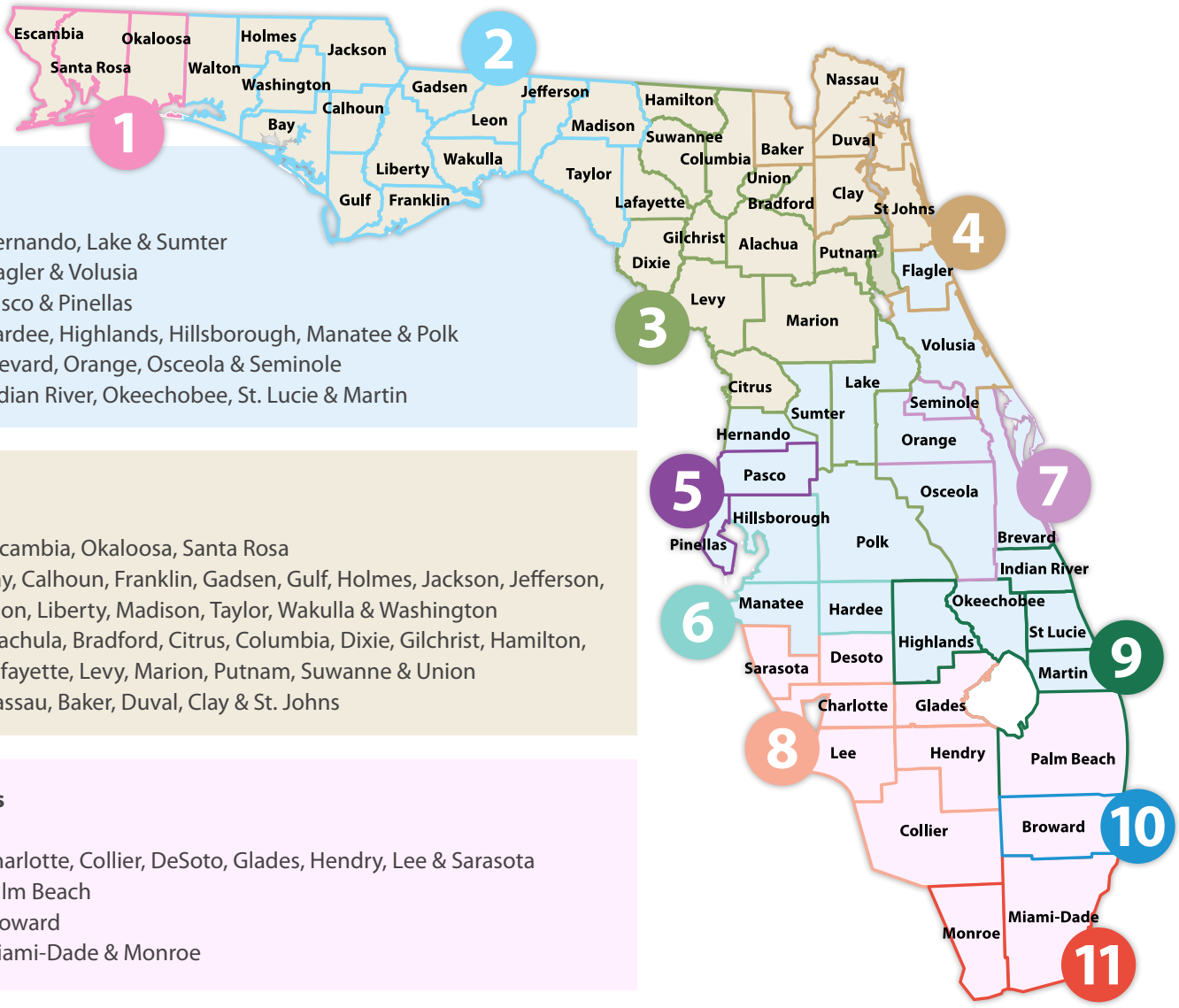


April Jung

Region 3: Hernando, Lake & Sumter
Region 4: Flagler & Volusia
Region 5: Pasco & Pinellas
Region 6: Hardee, Highlands, Hillsborough, Manatee & Polk
Region 7: Brevard, Orange, Osceola & Seminole
Region 9: Indian River, Okeechobee, St. Lucie & Martin

Brooke Fritz

Region 1: Escambia, Okaloosa, Santa Rosa
Region 2: Bay, Calhoun, Franklin, Gadsen, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla & Washington
Region 3: Alachula, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Marion, Putnam, Suwanne & Union
Region 4: Nassau, Baker, Duval, Clay & St. Johns

Yeslin Marcos

Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee & Sarasota
Region 9: Palm Beach
Region 10: Broward
Region 11: Miami-Dade & Monroe

Intake Form Completion Requirements for Sunshine, Humana, Amerigroup, Coventry Healthy Kids & Coventry Medicaid

Effective Immediately the Intake Form must be completed in its entirety in order to be accepted for Authorization approval. Intake forms that are not entirely filled out will be returned back to the provider for completion.

Please ensure that you complete the **times/per week** and **number of weeks** when **checking off** the attestation boxes for the fields below and certify that the plan of care information on the intake form **matches the patient's individual plan of care as documented in the patient's medical record**. The times/ per week and number of weeks should be the same on each Intake Form submitted in steps 1 through 3 as indicated , unless you are changing the POC. If there is a change in the POC you must submit to the referring provider and ATA-FL documentation of this change (i.e. a modification order).

It is also imperative that you **include the Evaluation Date** on each Intake Form. Lastly, you must include the unique NPI and name of the referring provider in each submission. This cannotbe the NPI of the treating therapist.

Please check box to confirm

Member's Plan of Care has been submitted and approved by ordering Provider and the frequency and duration are:

____ times/ per week ____ number of weeks

Please check box to confirm

The servicing provider has reviewed the approved Plan of Care with the Enrollee including the frequency and duration, and will provide these services.

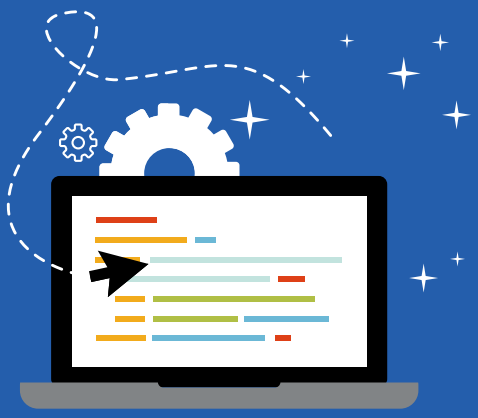
Please check box to confirm

Ordering Provider will be notified when therapy has been completed and whether the goals have been achieved (Member discharged) or Therapy was stopped.

Step 1: Fill out separate Patient Intake form for each discipline

Physical Therapy **Occupational Therapy** **Speech Therapy** **Evaluation Date (mm/dd/yyyy):** ## ## ## ##

Download the form at: http://ataflorida.com/pdf/patient-intake.pdf



Pre-Service Determination Letters

Effective 01/04/2016, Health Plan Pre-Service Determination letters will be issued to members, to notify them that their therapy services have been approved.

Medicare Part D Prescriber Enrollment… Time is Running Out

Beginning June 1, 2016, prescribers who write prescriptions for Part D drugs must be enrolled in an approved status or have a valid opt-out affidavit on file with Medicare in order for their prescriptions to be covered under Medicare Part D. Before opting out of Medicare, you should consider the following impacts:

- You will not be able to participate in a Medicare Advantage plan, which means that you will no longer be able to continue your participation in our Network and
- Your opt-out status lasts for two years and cannot be terminated unless within 90 days of your opt out designation

You can also contact the Medicare Administrative Contractor that services our area:

Florida First Coast Service Options
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021
888-845-8614
http://medicare.fcso.com/
http://medicareespanol.fcso.com/

To learn more about the options available to you, refer to the following chart:
http://healthnetworkone.com/partd-decision-chart

For more information on the prescriber enrollment requirements, visit:
http://healthnetworkone.com/partd-prescriber-enrollment

CREDENTIALING NEWS

If you have any questions or concerns, you may contact the Credentialing Director, Amy Long, at (305) 614-0361.

Expiration of Documents

As credentialing documents expire, you will receive requests to submit copies of your current licenses, DEA's and Malpractice Insurance. To be proactive, you can fax them to (305) 614-5055 as soon as you receive the new documents and we can update our records accordingly. If you participate with CAQH, you can upload these documents to your profile and we can obtain them directly from the Pro View site.

Florida Health Care Clinic (HCC) Exempt License

For all Florida therapy facilities contracted with the organization that hold a state of Florida Health Care Clinic (HCC) exempt license and do not hold any documentation verifying a CMS or applicable state on-site quality assessment will need to have site visits completed at initial credentialing and recredentialing.

Recredentialing Process

In order for your initial or recredentialing process to run smoothly, here are some helpful tips:

- Submit the credentialing applications timely
- Sign and Date the Consent & Release and Attestation pages
- Include all of the requested supporting documents (ie: License, DEA, CV, Malpractice Insurance, Accreditations, etc.)
- Ensure that supporting documents have been uploaded to CAQH, if applicable.
- Ensure that you have authorized HS1 Medical Management, Inc. or have CAQH set to "Global" so that we have access your information
- Ensure that your CAQH attestation is current

Law Against Health Care Fraud: Exclusion Provisions

Although most health care providers work hard to deliver quality care and submit correct claims for payment, some providers seek to exploit government health care programs for illegal personal gain. Health care fraud remains a serious problem for these programs. The U.S. Government Accountability Office has designated Medicaid as a program that is at high risk for improper payments. Improper payments "include those made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided." There are a number of Federal and State laws to deter and punish those who fraudulently seek to obtain improper payments from Medicaid. Federal laws include, but are not limited to, the following:

Under Section 1128 of the Social Security Act, HHS-OIG has authority to exclude individuals from participating in Federal health care programs, including Medicaid, for various reasons. Exclusions can be mandatory, meaning the HHS-OIG has no choice about whether to exclude, or discretionary, which means the HHS-OIG does have a choice. Exclusion is mandatory for convictions of program-related crimes, convictions relating to patient abuse, felony convictions relating to health care fraud, and felony convictions relating to controlled substances. Exclusion is discretionary for loss of license due to professional competence or financial integrity, convictions relating to fraud, convictions relating to obstruction of an investigation or audit, misdemeanor convictions relating to controlled substances, and participation in prohibited conduct such as kickbacks and false statements.

As a Federal health care program, Medicaid will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity. If someone on a provider's staff has been excluded from participation in a Federal health care program, the provider should not bill any Federal health care programs for any items or services furnished, ordered, or prescribed by the excluded individual. "Furnished" is a key word that refers to items or services provided or supplied, directly or indirectly, by an excluded individual or entity.

It is in the best interest of providers to screen potential employees and contractors prior to employment or contracting to ensure they are not excluded from participating in Federal health care programs. In addition, providers should regularly check the exclusions database to ensure that none of the practice's employees or contractors have been excluded.

CMS has issued guidance to State Medicaid agencies that they should require providers to screen their employees and contractors for exclusions by checking the database on a monthly basis. The guidance further advises States to require all providers to immediately report any exclusion information discovered. The List of Excluded Individuals/ Entities (LEIE) database is available at http://exclusions.oig.hhs.gov/ on the HHS-OIG website. Both licensed and unlicensed individuals may be excluded, so it is best to check for both. In addition to checking the LEIE, providers should check the Exclusions Extract, which can be accessed by visiting https://www.sam.gov/ on the System for Award Management website.

We're Just A Phone Call Or Click Away

If you have any changes to your practice, including demographic or provider additions/ terminations, please notify your ATA of Florida Provider Relations Representative.

Referrals/Authorizations

Sunshine, Humana, Amerigroup, Coventry Medicaid & Health Kids
Tel: 1 (855) 410-0121

Coventry Medicare & Commercial & Aetna
Tel: 1 (888) 560-6855
Fax: 1 (866) 231-6344

Provider Relations

Tel: 1 (888) 550-8800 Option 2
Fax: 1 (305) 620-5973

Claims

Sunshine, Humana, Amerigroup, Coventry Medicaid & Health Kids
Tel: 1 (877) 372-1273 Option 6

Coventry Medicare & Commercial & Aetna
Tel: 1 (888) 560-6855 Option 2

Our Website

For our most up to date information and news visit us on our website at: www.ataflorida.com

To report suspected Fraud, Waste, and Abuse, or any Compliance issue:

Tel: 1 (866) 321-5550

Annual Quality Improvement Documents

Annually the Quality Improvement (QI) Department develops Quality documents that include a QI Evaluation, Program Description, and Work Plan. The development of the Quality documents satisfies Health Plan and NCQA Accrediting body requirements. The QI Evaluation analyze the QI department's previous year quality indicators, key accomplishments, identify any areas needing improvement, and develop action plans to improve results.

The Program Description and Work Plan establish objectives, goals, QI activities, and the QI Program Structure for the current year.

Copies of the annual QI documents are available by contacting the QI department at the address below.

2001 South Andrews Avenue
Fort Lauderdale, FL 33316
Phone: (800) 422-3672 Ext. 4701
Fax: (305) 614-0364

MMA Managed Medical Assistance Member Express Enrollment

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Under Express Enrollment there is no change to:

- Who is eligible to enroll
- Who is required to enroll
- Services offered under the MMA program

Health plan enrollment will be effective the same day the individual's Medicaid application is approved and the Plans will be paid a prorated capitation rate. Individuals may choose an MMA plan upon submission of a complete Medicaid application through the ACCESS system at www.smmcexpressenrollment.com. Concurrent with completion of their Medicaid eligibility application, mandatory recipients will be informed of:

- Plans available in their area;
- Guidance about selecting a health plan; and
- How to make a plan choice.

If no plan is chosen the Agency will automatically assign the recipient to a health plan once determined eligible and the Plan enrollment will become effective when the applicant is determined eligible for Medicaid.

What if a member appears to be inactive with the Health Plan?

Do not turn the member away. Individuals can be enrolled in a plan any time during the month so it is important providers first check the Florida Medicaid Managed Information System (FLMMIS) for eligibility prior to rendering services.

How can I verify eligibility for Medicaid Program recipients?

By calling the Automated Voice Response System (AVRS) at 800-239-7560 or by isit the fiscal agent's website at http://mymedicaid-florida.com/.

https://www.smmcexpressenrollment.com/