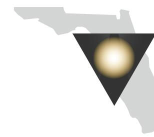


AMERICAN THERAPY
ADMINISTRATORS OF FLORIDA

Provider Newsletter

2019 Q4

CLAIMS NEWS

Important Claims and Billing updates

Proper Coding:
Procedure code **97014** -- electrical stimulation unattended is not a covered code by Medicare (NOTE: 97014 is not recognized by Medicare.) Use G0283 when reporting unattended electrical stimulation for other than wound care purposes

Medicare considers CPT Code **97010** (hot/cold packs) a "bundled" service. When a service is bundled, it means that the reimbursement for the code is built into or grouped with the reimbursement for another code.
Both Codes 97010 and 97602 are bundled. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, payment is never made separately for these codes. If billed alone, either code will be denied using the existing EOMB/MSN language.

Upcoming billing requirements for Medicare: Therapy Assistant Modifiers

CMS finalized its proposal to establish 2 new modifiers to identify services provided by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs), as required by the Bipartisan Budget Act of 2018. Beginning January 1, 2020, claims from all providers of PT and OT services must include these modifiers for services furnished in whole or in part by a PTA or OTA.

COUNTINUED ON PAGE 2

MEDICARE LINE OF BUSINESS

New Health Plan Implementation – CarePlus

Effective JANUARY 1, 2020 American Therapy Administrators of Florida/Health Network One (ATA-FL/HN1) will be the mandatory specialty network for Outpatient physical therapy, speech therapy and occupational therapy services provided in a free-standing Facility or office setting (i.e. POS 11), for CarePlus' Medicare enrolled members.

Medicare Coverage Area
Hillsborough, Pasco, Pinellas, Polk, Orange, Osceola, Seminole, Sumter, Marion, Lake, Duval, Clay and Volusia counties.

COUNTINUED ON PAGE 4

MEDICAID AND HEALTHY KIDS LINES OF BUSINESS

New Health Plan Implementation – Community Care Plan

Effective JANUARY 1, 2020 American Therapy Administrators of Florida/Health Network One (ATA-FL/HN1) will be the mandatory specialty network for Outpatient physical therapy, speech therapy and occupational therapy services provided in a free-standing Facility or office setting (i.e. POS 11), for CCP's Medicaid and Healthy Kids enrolled members.

Medicaid Coverage Area
Region 10

Healthy Kids Coverage Area
Region 9, 10 and 11

COUNTINUED ON PAGE 4

Profound level of impairment definition

The following is a discipline specific checklist with guidelines to assist in the determination of a profound level of impairment. The items listed in the checklist are part of what may result in a profound level of impairment authorization. Submitting these elements may result in a profound, level 5. The entire clinical record is reviewed, and may include a peer to peer and the entire review determines the level authorized.

SLP Profound Severity Checklist:

- Standardized test scores 64 and lower or below 1st percentile
- Extremely limited communication ability- simple speech and communication is very difficult. They often have to rely on basic gestures or sounds to communicate. (May need use of AAC device, PECS, etc.)
- Limited functional expression and /or comprehension. Seriously interferes with and/or prevents communication.
- Many articulation errors and/ or phonological processes are present. Connected speech mostly unintelligible. No error sounds stimulable for correct production.
- Voice or fluency disorder significantly impairs communication and intelligibility. Avoidance of speaking situations may be observed. Frustration behaviors are present. Awareness of dysfluent behavior.
- Dysphagia showing one or more of the following: significant oral stage bolus loss or retention, unable to clear; silent aspiration with 2 or more consistencies; non functional volitional cough; unable to achieve swallow. NPO: unable to tolerate any P.O. safely.
- For oral aversion and feeding disorders, such as oral motor (delayed skills affecting oral phase of swallowing) or oral sensory processing disorders (hypersensitivity to smell, taste, or textures of foods): patient may struggle to meet basic nutritional requirements and may require full or partial nutritional support as a result of their restrictive dietary intake.

OT Profound Severity Checklist:

- Self care deficits resulting in maximal to total assistance.
- Sensory system deficits which contribute to profound delays in functional performance.
- Cognition deficits requiring maximal cues for redirection to stay on task or to follow 1 step commands.
- Standardized testing resulting in standard deviations 2.5 or greater from the norm.

PT Profound Severity Checklist:

- Standardized test scores 80% or greater developmental delay. Or standardized test scores 80% disability or greater (Per objectives standardized tests scores).
- Dependent on adults for mobility and positioning.

COUNTINUED FROM PAGE 1

Important Claims and Billing updates

These new modifiers are be appended on the same line of service as the respective PT, OT, or SLP therapy modifiers (GP, GO, GN):

- CQ Modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- CO Modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
- The 3 therapy modifiers will continue in effect, unchanged, as follows:
- GP – services delivered under an outpatient physical therapy plan of care
- GO – services delivered under an outpatient occupational therapy plan of care
- GN – services delivered under an outpatient speech-language pathology plan of care

Your PATHWAY to Reporting ...

FRAUD WASTE & ABUSE

All HN1/ATA-FL providers are required to report concerns about actual, potential or perceived misconduct to the HN1/ATA-FL Corporate Compliance Department at:

1 (866) 321-5550

Referring Provider NPI for Medicaid

Florida Medicaid is preparing for compliance with the federal requirements that all ordering or referring physicians or other professionals providing services to Medicaid recipients must be enrolled with the State Medicaid agency.

The new Error codes, Explanation of Benefits (EOB) codes, and new Claim Adjustment Reason Code/Remittance Advice Remark Code (CARC/RARC) combinations described below are informational only and will not result in a denial.

Effective August 15, 2019, the Florida Medicaid Management Information System (FMMIS) will begin checking that the National Provider Identification (NPI) number for referring, ordering, and attending providers is present on fee-for-service claims and encounter submissions. This requirement is applicable for claims and encounters that include a date of service on or after August 15, 2019.

The EOB codes will post on the Remittance Advice (RA) and the CARC/RARC combinations will post on the X12 835 claim payment / advice transaction. Providers that receive the edits should verify that the referring, ordering, or attending provider supplied on the claim or encounter is identified by a valid NPI number. NPI records may be reviewed at **https://npiregistry.cms.hhs.gov**

Providers may continue to receive the aforementioned edits even after the referring, ordering, or attending provider's NPI number is verified and properly documented on the claim or encounter if the referring, ordering, or attending provider is not enrolled in Florida Medicaid.

Florida Medicaid will perform outreach to referring, ordering, and attending providers for enrollment compliance in the coming months. Florida Medicaid will monitor provider enrollment levels and issue multiple provider alerts prior to taking any action to deny claims and encounters that do not identify referring, ordering, and attending providers by a valid NPI number that is known to Florida Medicaid.

Institutional providers will receive the following edits if the attending or referring practitioner is NOT identified by an NPI number:

- Error code 1275 Attending Provider NPI missing CARC/RARC combination 206/N253
- Error code 1278 Attending Provider NPI not enrolled/registered with State Medicaid Agency CARC/RARC combination 208/N253.
- Error code 1260 Referring Provider NPI missing CARC/RARC combination 206/N286.
- Error code 1262 Referring Provider NPI not enrolled/registered with State Medicaid Agency CARC/RARC combination 208/N286.

Professional providers will receive the following edits if the ordering or referring practitioner is NOT identified by an NPI number:

- Error code 1260 Referring Provider NPI missing CARC/RARC combination 206/N286.
- Error code 1262 Referring Provider NPI not enrolled/registered with State Medicaid Agency CARC/RARC combination 208/N286.
- Error code 1280 Ordering Provider NPI missing CARC/RARC combination 206/N265.
- Error code 1281 Ordering Provider NPI not enrolled/registered with State Medicaid Agency CARC/RARC combination 208/N265.

COUNTINUED FROM PAGE 1

New Health Plan Implementation — CarePlus

Continuation of Care (COC)

Continuation of Care (COC) period is up to 30 days from the date that the member switched to CarePlus Medicare from another Medicare Advantage plan. The COC period ends when the old auth expires or when the 30 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.

Service Exclusions

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 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.

Claims Submission

If you were issued an authorization by CarePlus, please submit your claims for dates of service on or after January 1, 2020 to ATA-FL/HN1. Please submit your paper claims to ATA- FL/HN1 at P.O. Box 350590, Fort Lauderdale, FL 33335-0590; or submit your Electronic Claims (EDI) via Professional Payer ID 65062 or Institutional Payer ID 12k89. Along with your submittal of claims, providers may be required to submit written documentation such as prior existing orders, prior authorizations and treatment plan/ plan of care, in order to receive payment on their claim.

Patient Responsibility

Providers may confirm co-pays, deductible, co-insurance and MOOP details through CarePlus' website at: **https://careplushealthplans.com/careplus-providers**.

COUNTINUED FROM PAGE 1

New Health Plan Implementation — Community Care Plan

Continuation of Care (COC)

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.

Service Exclusions

Dual enrolled members, Tertiary cases, Scholastic School based Therapy, Hospital Inpatient Therapy, Home Health, Partial Day Rehabilitation, Spinal Cord Injuries, PPEC, Nontraditional 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.

Claims Submission

If you were issued an authorization by CCP, please submit your claims for dates of service on or after January 1, 2020 to ATA-FL/HN1. Please submit your paper claims to ATA- FL/HN1 at P.O. Box 350590, Fort Lauderdale, FL 33335-0590; or submit your Electronic Claims (EDI) via Professional Payer ID 65062 or Institutional Payer ID 12k89. Along with your submittal of claims, providers may be required to submit written documentation such as prior existing orders, prior authorizations and treatment plan/plan of care, in order to receive payment on their claim.

Patient Responsibility

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

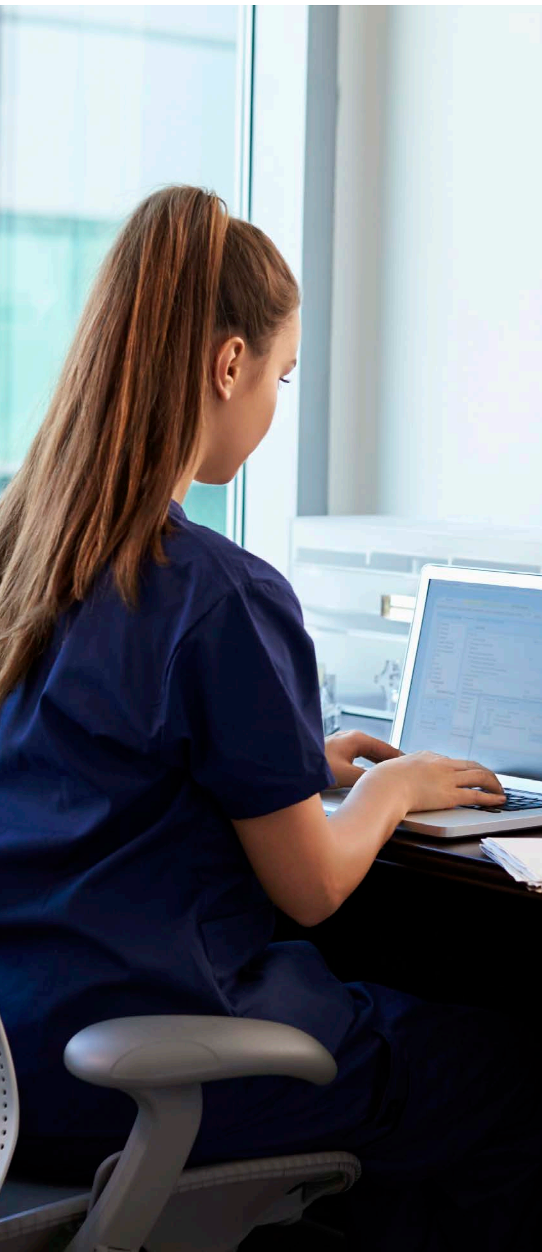
Annual Quality Improvement Documents

Annually the Quality Improvement (QI) Department develops Quality documents, which includes a QI & UM Evaluation, Program Description, and Work Plan. The development of the Quality documents satisfies Health Plan and NCQA Accrediting body requirements. The QI & UM 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

Clinical Practice Guidelines

ATA-FL uses Apollo, Milliman Care, or our Health Plan partner Clinical Guidelines (depending on the LOB) for Medical necessity determinations. These guidelines are based on appropriateness and medical necessity standards; each guideline is current and has references from the peer-reviewed medical literature, and other authoritative resources such as CMS Medicare. For any medical necessity Recommendation of Denial, the Medical Director shall make an attempt to contact the requesting provider for peer to peer consultation. The Apollo, Milliman Care, or our Health Plan partner Clinical Guidelines are reviewed and approved by HS1 Medical Advisory committee annually, and are available in both electronic and hard copy format. If a provider would like a copy of a guideline they may contact their assigned Provider Relations Rep and a copy will be provided.



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

**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.

Providers and all health care providers employed by and/or associated with the contracted provider, group or facility shall meet all credentialing and re-credentialing requirements in order to render services to beneficiaries managed by ATA-FL.

Providers who are not credentialed by ATA-FL shall not render services to beneficiaries managed by ATA-FL. Please refer to your provider service agreement for more details. Authorization requests that include a non-participating providers will be recommended for denial to the plan as a nonparticipating request.

If you have providers employed by your practice that are not currently credentialed by ATA-FL, please contact your Provider Relations Representative or our Provider Relations Department to begin the credentialing process for the non-participating provider.