Provider Reference Manual

Sunshine Health Medicaid
Serious Mental Illness (SMI) Specialty Plan
and Child Welfare Specialty Plan

sunshine health

THERAPY NETWORK OF FLORIDA

Table of Contents

ADDRESS:

2001 South Andrews Ave
Ft. Lauderdale, FL 33316

TOLL FREE:

(888) 550-8800

FAX:

(305) 620-5973

Welcome!

Therapy Network of Florida (TNFL) welcomes your participation in the provider network. We are pleased that you have chosen to join our organization. As a participating provider, you play a central role in the delivery of covered services to our affiliated health plan enrollees.

TNFL's provider manual is intended to serve as a reference guide to assist you and your staff in providing outpatient Physical Therapy (PT), Occupational Therapy (OT) and/or Speech Therapy (ST) services to our affiliated members. We hope that you will find the information included in this document to be concise and useful in your role as a therapy provider. The intention of this provider manual is not to dictate to the therapy provider the recommended plan of care, which remains entirely in your hands as a licensed, qualified practitioner.

TNFL will send you updates to this provider manual from time-to-time, as the need to amend the content is identified. Meanwhile, due to the rapid and frequent changes that occur in health care policy and regulations, you may come across a discrepancy between a current law and the process outlined by TNFL. In such instances, the most current policy adopted by the member's health plan, federal and/or state regulations and laws, and/or the terms of your Provider Agreement will supersede any such information contained in this provider manual.

Thank you for the quality services you provide to our health plan enrollees. We look forward to a long and mutually beneficial relationship with you.

Sincerely,

Luis Goveo-Ortiz, M.D. TNFL,

Medical Director

Quick Reference Guide

- Provider relations - 888-550-8800 option 2
- Provider relations fax - 305-620-5973
- Authorization - 888-550-8800 option 1
- Claims 877-372-1273
- Electronic claims submission (EDI) direct data entry (DDE) through the HS1 web portal, or through the clearinghouse, change healthcare, using:
  Professional Payer ID: 65062
  Institutional Payer ID: 12k89
- Electronic remittance advice (ERA) are provided via change healthcare. Provider must complete change healthcare era provider setup
- Paper claims submission:
  P.O. BOX 350590
  Fort Lauderdale, FL 33335-0590
- 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)
- Web portal access requests administered by health system one (HS1). Please complete the HS1 web portal access form online at https://mytnfl.com/pwp
- Provider web portal link https://mytnfl.com/hs1webportal

Authorizing Services

Medicaid, Serious Mental Illness (SMI) Specialty Plan and Child Welfare Specialty Plan enrollees ages > 3

All rendering providers MUST submit the following Critical Elements with the authorization request. Providers must submit via the Provider Web Portal at https://mytnfl.com/hs1portal. If you are unable to send the request via our Web Portal, contact the Authorization or Provider Relations department.

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./ Chiropractor).
2. POC with diagnosis signed/dated by the referring provider (Physician/ARNP/P.A./Chiropractor) 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./ Chiropractor) recorded on or after the recorded date of the treating therapist's signature.
   - 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, TNFL will not be able to approve the authorization request. Based on TNFL'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://mytnfl.com/hs1portal/
- In addition, TNFL 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 2 calendar days.
  - 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 Critical Elements will be referred to the health plan with recommendation for denial.

Request for an Upgrade of an Existing Authorization:

- TNFL will only issue authorizations for upgrades when a change in diagnosis, worsening in condition or a change in test scores is submitted.
- Upgrades will not be authorized retrospectively (after the treatment period).
- The provider must submit the Upgrade request via fax to TNFL at 877-583-6440.
- The Upgrade Request must include the following:
  - The completed TNFL Upgrade Request Form
  - New POC if there is a change in diagnosis, signed/ dated by the referring provider (Physician/ARNP/ P.A./Chiropractor), 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 of all the rendered DOS on the Upgrade Request Form

Review Process for an Upgrade Request:

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

A. If Approved:
   - TNFL will upgrade the request accordingly.
   - 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 TNFL 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./ Chiropractor).

B. Request an authorization via the Provider Web Portal at https://mytnfl.com/hs1portal/ or via fax to TNFL at 1-855-410-0121.

C. Submit the 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, TNFL will review the submitted documentation. TNFL 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 separate authorizations via the Provider Web Portal at https://mytnfl.com/hs1portal.
2. All documentation requirements, including the 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.

TNFL 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, TNFL 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 TNFL 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 TNFL website www.mytnfl.com under provider resources. Providers must submit the form via fax to TNFL at 1-855-410-0121. Upon receipt of the authorization request an TNFL 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. If after Peer to Peer, TNFL clinician is in agreement with the rendering therapist's Level assessment of the patient's level of impairment, authorization is approved.

B. If after Peer to Peer, TNFL clinician is not in agreement with the rendering therapist's Level assessment of the patient's level of impairment, a recommendation for denial will be offered to rendering therapist.

C. If after Peer to Peer, the rendering therapist agrees that the member is at a different impairment level than originally written on the documents:

- The rendering therapist may request to withdraw current request and resubmit documentation with an addendum to the POC, or new POC supporting the updated level of impairment.
- If the rendering therapists is not able to resubmit documentation to supply an addendum or new POC with the updated level of impairment, then the case will be referred to the Health Plan for a Recommendation for Denial.

Note: If a Peer to Peer review is unable to be completed, the TNFL clinician will refer the case for Recommendation for Denial to the Health Plan.

Level assignments

Issuance of a Level:

Upon receipt of the authorization request, an TNFL 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;

Service Exclusions

Members under 3 years of age, Tertiary cases, Scholastic Therapy, PPEC, Early Intervention Services (EIS), 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 not managed by TNFL. Please contact Sunshine Health for coverage of services not managed by TNFL.

EPSDT

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under the age of 21 years. The EPSDT benefit for this population is designed to assure that children receive early detection and care in order to address health problems as soon as early as possible.

TNFL has an established policy to ensure that all eligible members are provided with medically necessary services when these have been identified through an EPSDT/well-child screening. When notified, TNFL will authorize medically necessary services for children when such services have been identified and ordered by a participating licensed physician, advanced registered nurse practitioner or physician's assistant as part of an EPSDT/ well-child screening.

Documentation

Plan of Care Documentation:

TNFL 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

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./Chiropractor) LMN, Prescription or Referral Form includes their NPI, Credentials and date of signature.

Case Scenarios:

When an TNFL 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?

Progress Report Checklist:

In order to reflect that continuing therapy services are medically necessary, progress reports should include at a minimum the following when submitted for re-authorization:

- Start of care
- Time period covered by the report
- Medical and therapy treatment diagnosis (ICD 10 codes)
- Statement of the individual's functional level at the beginning of the progress report period (baseline);
- Statement of the patient's current status compared to evaluation baseline data and prior progress reports, including objective measures of member's performance in functional terms that relate to treatment goals;
- Any progress towards the goals in objective, measurable terms using consistent and comparable methods;
- Number of sessions, location and attendance record;
- Clinical impression stating current level of impairment (mild, moderate, severe or profound)
- Changes in prognosis and why;
- Changes in Plan of Care;
- Changes in goals and why if modifying or adding new goals;
- Consultations with other professionals or coordination of services, if applicable;
- Signature and title of qualified professional responsible for the therapy services (must be completed by the therapist, not the therapist assistant);
- Signature of referring physician, physician assistant or nurse practitioner.

Note: We do not encourage the practice of replacing a re-evaluation with a detailed progress report. However, we understand that the patient may not always meet all their long-term or short-term goals by the end of the certification period. You can carry them over to the next certification period by meeting the requirements listed above in lieu of a re-evaluation to request authorization for the next certification period.

Case Rate 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 TNFL to meet data reporting responsibilities to the health plan and regulatory entities, enables TNFL to give the Provider accurate reports and profiles and provides TNFL with information we need for internal monitoring and review.

Medicaid, Serious Mental Illness (SMI) Specialty Plan and Child Welfare Specialty Plan enrollees ages > 3

Non-developmental delay 60 day Authorization Providers are required to submit claims encounters for all services rendered, each and every visit and service are to be reported in the form of a claim to TNFL. This claim encounter ensures that the Plan's members are receiving therapy services as authorized by TNFL per the POC. TNFL 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 program. The state uses the encounter data to review and ensure that therapy services are delivered to the Plan's Medicaid, Serious Mental Illness (SMI) Specialty Plan and Child Welfare Specialty Plan enrollees ages > 3.

Payment of Levels:

Payment of Level may result in a maximum of one (1) Level payment during the episode of care (60 days).

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

Medicaid, Serious Mental Illness (SMI) Specialty Plan and Child Welfare Specialty Plan ages > 3 Developmental Delay 180 day Authorization

Providers are required to submit claims encounters for all services rendered, each and every visit and service are to be reported in the form of a claim to TNFL. This claim encounter ensures that the Plan's members are receiving therapy services as authorized by TNFL per the POC. TNFL 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 program. The state uses the encounter data to review and ensure that therapy services are delivered to the Plan's Medicaid, Serious Mental Illness (SMI) Specialty Plan and Child Welfare Specialty Plan enrollees ages > 3.

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 TNFL 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.

TNFL 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 TNFL's receipt of claim encounters.

TNFL 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 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 TNFL 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 TNFL 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 TNFL to meet data reporting responsibilities to the health plan and regulatory entities, enables TNFL to give the Provider accurate reports and profiles and provides TNFL with information we need for internal monitoring and review.

Claim Submission:

The preferred method of claim submission is EDI. Providers may use the HN1/HS1 Web Portal (www.healthsystemone.com) to submit claims. Our Web Portal providers may use the portal 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 www.mytnfl.com to register for an account.

If your office prefers to submit claims electronically, please be advised that we are now receiving claims through our EDI clearinghouse 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 TNFL via this Payer ID. Change Healthcare will notify the providers if their electronic claims were accepted or if claims were rejected. Providers may contact Change Healthcare 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. UB04) to:

Therapy Network of Florida Claims
Processing Center
P.O. Box 350590
Fort 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 providers of TNFL have 365 days from the date of the EOP/EOB to request an adjustment for a processed claim. However, TNFL 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 TNFL 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. 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 TNFL to meet data reporting responsibilities to the health plan and regulatory entities, enables TNFL to give the Provider accurate reports and profiles and provides TNFL 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 TNFL 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. TNFL strictly adheres to state and federal claims processing guidelines for Medicaid 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 sixty (60) 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.

Member Services & Benefits

TNFL 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.

Service Exclusions

Members under 3 years of age, Tertiary cases, Scholastic Therapy, PPEC, Early Intervention Services (EIS), 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 not managed by TNFL. Please contact Sunshine Health for coverage of services not managed by TNFL.

Providers have a responsibility to provide optimal care to members without regard to age, race, gender, religious background, national origin, disability, and sexual orientation, source of payment, veteran status, claims experience, social status, health status or marital status.

Continuity of Care

Medicaid, Serious Mental Illness (SMI) Specialty Plan and Child Welfare Specialty Plan enrollees ages > 3

Sunshine Health Plan (COC) period is up to 60 days from the date that the member switched to Sunshine Health Plan's Medicaid, Serious Mental Illness (SMI) Specialty Plan and Child Welfare Specialty Plan product from another MMA 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 TNFL to continue providing these services during the Continuation of Care Period. Members may also contact the health plan to locate a participating therapist. TNFL 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.

Some of the most common FWA practices include:

Billing for services not rendered

Upcoding of billed services or misusing codes on a claim

Altering/falsifying documentation

Using unlicensed individuals to provide services

Excessive use of units

Misuse of member benefits

How to report suspected or confirmed fraud

Providers may report suspected or confirmed fraud, waste or abuse in the state Medicaid program through any of the following channels:

AHCA consumer complaint hotline: (888) 419-3456 or via the complaint forms that can be found on the AHCA website

Florida Attorney General's Office: (866) 966-7226

Florida Medicaid Program Integrity Office: (850) 412-4600

Please note that the Division of Insurance Fraud Complaint form may be found on the Florida Department of Financial Services website.

Additionally, you can report these violations to TNFL directly, the Federal Government, or to the affected Health Plan(s). You can also file your report anonymously.

Fraud, Waste & Abuse Hotline:

866-321-5550 (Toll-Free)
You can also file an anonymous report, if you want.

Mail your report to:

Special Investigative Unit (SIU)
Attn: Marjorie Henderson
2001 South Andrews Avenue
Fort Lauderdale, Florida 33316

Fax your report to:

(866) 276-3667
Attn: Marjorie Henderson
This is a dedicated Compliance line

Email your report:

SIU@healthsystemone.com

TNFL requires all contractors (and providers) and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care/services to beneficiaries. Examples of said violations include: bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, illegal remuneration schemes, identity theft, etc.

Fraud, Waste, and Abuse and Compliance

The FWA training is available at https://mytnfl.com/trainings where providers can view, print or download.

False Claims Act

- The False Claims Act imposes liability on any person or entity that improperly receives or avoids payment to the government. The Act prohibits the following:
- Knowingly presenting or causing to be presented a false claim for payment or approval
- Knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act
- Falsely certifying the type or amount of property to be used by the government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying government property from an authorized officer of the government
- Knowingly making, using or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the government.
  - An example may be a health care provider who submits a bill to Medicare for medical services she knows she has not provided. This could also include falsifying medical records or documentation to obtain or retain money from the federal government. No specific intent to defraud is required, because the FCA defines "knowing" as not only actual knowledge but also acting in deliberate ignorance or reckless disregard of the truth or falsity of information, such as repeatedly ignoring government bulletins and transmittals regarding billing and coverage for physical therapist services.

For more information regarding the False Claims Act, visit the Centers for Medicare and Medicaid Services Website.

HIPAA

Providers have a responsibility to keep beneficiaries' protected health information (PHI) strictly confidential in compliance with the Health Insurance Portability and Accountability Act (HIPAA) standards, and to provide necessary enrollee PHI to TNFL or the member's health plan of record, also in accordance with HIPAA standards, when required for payment, treatment, quality assurance, regulatory, data collection and reporting activities.

Providers are responsible to notify members' health plans or TNFL's compliance office when a HIPAA breach or disclosure occurs. Please be sure to not further violate HIPAA standards by sending PHI via unsecure (non-encrypted) email to anyone, including TNFL. You can report violations to TNFL directly via email SIU@healthsystemone.com or by telephone 1-866-321-5550.

Provider Trainings

All providers with TNFL, are required to complete the Provider Trainings, within thirty days of their contract effective date and annually thereafter. The trainings can be located via the web at: mytnfl.com/trainings. You may complete the trainings on any desk top or mobile device for ease of access and completion. Your attestation will confirm that your office has received all mandatory trainings for the year. Should you want a copy of the trainings for your office, they can be downloaded from the attestation page. **NOTE:** For providers who function under more than one Tax ID; please be sure to complete an attestation for each Tax ID that is contracted with TNFL.

TNFL requires, in accordance with state/federal regulations that compliance, FWA and HIPAA trainings be completed by contractors and subcontractors, as well as their employees, within 30 days of hire/contracting and annually thereafter. Records of the training must be maintained and readily available at the request of TNFL's Compliance Officer, AHCA, CMS or agents of both agencies, upon request.

Providers must complete training on topics as required by s. 6032 of the Federal Deficit Reduction Act, which include:

a. The Federal False Claims Act;

b. The penalties and administrative remedies for submitting false claims and statements;

c. Whistleblower protections under federal and State law;

d. The entity's role in preventing and detecting fraud, waste and abuse;

e. Each person's responsibility relating to detection and prevention; and

f. Providers' responsibilities to ensure non-discrimination.

Providers or their employees who have not taken the aforementioned trainings can do so by logging into to the TNFL training portal https://trainings.healthnetworkone.com/tnfl.

Quality Improvement

Provider Participation in Quality Improvement Procedures HN1 TNFL has a comprehensive Quality Improvement Program, which includes the following:

- Quality Improvement (QI) Indicators that measure the outcomes of process of care and service, such as: referral timeliness, over-/underutilization rates, denial recommendations, denial overturns, inter- rater reliabilities, telephonic accessibility, etc.
- Recredentialing process that includes the timeliness by all participating providers in order to comply with the three-year recredentialing process.
- Peer review process that includes inter-rater reliability audits of providers, medical records reviews, annual approval of clinical practice guidelines and the Peer Review Committee process when a quality-of-care issue has been identified and researched that requires a determination to be made by a panel of peers. All participating providers are obligated to comply with the requirements of the Quality Improvement Program, as indicated in your Provider Service Agreement.
- The QI Program implements quality improvement activities includes, but is not limited to: health plan member complaints monitoring and investigation, developing corrective action plans for provider satisfaction surveys, annual review of policy/ procedures, and annual development of program evaluations and descriptions.

Credentialing, Demographic Changes or Provider Termination

TNFL expects network providers to check the Office of the Inspector General (OIG) or General Services Administration (GSA) exclusion databases for all staff, volunteers, temporary employees, consultants, boards of directors and any other contractor that would meet the requirements as outlined in §§1128 and 1128A of the Social Security Act. Network providers may not knowingly become affiliated with an individual or entity, as defined in the Federal Acquisition Regulation at 48 CFR 2.101 of a person described in 42 CFR 438.610(a)(1); or subcontractors on the discriminatory vendor list maintained by the Department of Management Services in accordance with s.287.134, F.S.

Federal program payment may not be made for items or services furnished or prescribed by an excluded provider or entity. TNFL (as a delegate of the Health Plan) cannot use federal or state funds to pay for services or items furnished by a provider, supplier, employee, contractor or subcontractor excluded by the OIG or the GSA.

TNFL will review the OIG's "List of Excluded Individuals and Entities (LEIE)" and the GSA's "Excluded Parties List (EPLS)" now known as "System for Award Management (SAM)", as well as the Florida Agency for HealthCare Administration's (AHCA) listing of suspended and terminated providers before hiring or contracting any provider, employee, temporary employee, volunteer, consultant, governing body member or subcontractor.

TNFL will also monitor these named exclusion lists on a monthly basis thereafter along with any other mandated state/federal databases, applicable to TNFL lines of business. It is TNFL's expectation that its network providers will adopt the same onboarding and monitoring review process for their practices.

As needed, TNFL, Health Plans, and Federal agencies perform ad hoc provider practice "mystery shopper" calls or site visits to measure variables, including but not limited to, provider roster accuracy, urgent, and routine appointment availability, currently accepting new enrollees, and any barriers to scheduling appointments experienced by enrollees.

Please note: Traveling therapists are still linked to an address on your roster and should be verified accordingly should your practice receive a call requesting roster validation for a therapist who is not stationed at an office.

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 TNFL.

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

Provider Therapist Permanent License

Provider must notify TNFL 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 TNFL.

Note: Please notify us prior to opening a new facility or when relocating an existing facility so that TNFL can credential the new location. Services may not be provided to Sunshine members at a location that is not credentialed.

Demographic Changes or Provider Termination Requirements

The accuracy of provider demographic and practice data plays an important part in the success of a medical practice. Having accurate data helps connect you with members searching for a provider. It also supports claims processing and compliance with regulatory requirements.

Participating practices are required to notify TNFL 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
- If your practice is or is not accepting new patients
- Changes of ownership
- Changes in hours of operation
- Changes in Languages spoken/written by staff
- Changes in Ages/genders served
- Changes in appointment availability

The Provider Service Agreement states, you are required to notify TNFL of any terminations 90 days prior to the termination. Appointments for non-urgent care services shall be provided within 14 days of a request for services for the diagnosis or treatment of injury, illness or other health condition. Urgent medical care services shall be provided within 48 hours of request for therapy services, and that do not require an authorization within 96 hours of request for services which require an authorization (i.e. evaluations and re-evaluations.)

IMPORTANT: If your office is unable to meet the above appointment requirements, you will not be able to participate in the line of business.

Additional Information

- Speech-language pathologists who are provisionally licensed must be:
  - In the process of qualifying for a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association.
  - Supervised by a Medicaid enrolled licensed speech language pathologist linked to the therapy group.
    - > It is important to note according to AHSA's CF requirements, an SLP CF does not require a co-signature of the supervising therapist. For additional information, you may locate "A Guide to the ASHA Clinical Fellowship Experience" at https://www.asha. org/certification/clinical-fellowship/.
- Physical Therapists and Speech-Language Pathologists with temporary licenses may enroll as Medicaid providers.
  - TNFL requires all licensed or temporary licensed therapists rendering services to Medicaid enrollees to maintain active Medicaid enrollment with Florida Medicaid as either Limited Enrolled or Fully Enrolled enrollment status.

All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Policies are available on the Agency for Health Care Administration's (Agency) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

For additional information regarding Medicaid provider enrollment, you may locate the Agency for Health Care Administration's Provider Enrollment Policy at https://ahca.myflorida.com/medicaid/review/ General/59G-1.060_Enrollment.pdf

Provider Relations

If you have any questions about this information, changes to your practice, including demographic or provider additions/ terminations, please notify your TNFL Provider Relations Representative at: 1.888.550.8800 option 2.