Aetna Better Health (Coventry) Medicaid and Healthy Kids

Provider Reference Manual

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Authorizing Services Medicaid & Healthy Kids

All rendering providers MUST submit the following Four Critical Elements with the authorization request. Providers may submit via the Provider Web Portal at https://asp.healthsystemone.com/hs1providers or via fax to TNFL at 1-855-410-0121.

1. Prescription or Referral Form (N/A for re-evaluations)
   a. Evaluation;
   b. New POC/evaluation must be signed by the treating Therapist;
   c. Expired POC from the certification period that just ended must be signed by the treating Therapist and referring provider (physician/ARNP/P.A.).
2. A completed TNFL Intake Form (N/A to Providers using the Provider Web Portal) including 3 attestations
3. POC with diagnosis signed/dated by the referring provider (physician/ARNP/P.A.) and/or Letter of Medical Necessity (LMN)
   a. The Plan of Care must include the evaluation and the start and stop dates
   b. 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
   c. 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.
4. Standardized Assessment Scores clearly denoted

CRITICALLY IMPORTANT: If any of the above elements are missing, TNFL will not approve the authorization request. Based on TNFL 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.

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 TNFL delegated responsibilities, the case will be referred to the health plan with recommendation for denial.

PROVIDER NOTIFICATION OF AUTHORIZATION:

- Via the Provider Web Portal at: https://asp.healthsystemone.com/hs1providers
- In addition, TNFL will fax the treating provider an authorization indicating the Level and the authorization period.

- Expedited/Urgent requests are completed within 24 hours for Medicaid members.
- Authorization requests received without the 4 Critical Elements will be referred to the health plan with recommendation for denial.

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.

REQUEST FOR AN UPGRADE OF AN EXISTING AUTHORIZATION:

- TNFL 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 TNFL at 877-583-6440.
- The Upgrade Request must include the following:
    - The completed TNFL 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:

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

If Approved:

- TNFL 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.

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.
    a. New POC/evaluation must be signed by the treating Therapist.
    b. 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 https://asp.healthsystemone.com/hs1providers or via fax to TNFL 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, 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 two separate authorizations via the Provider Web Portal at https://asp.healthsystemone.com/hs1providers or via fax to TNFL 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.

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 https://therapynetwork.com/fl under the Forms tab. Providers must submit the form via fax to TNFL at (855) 410-0121. Upon receipt of the authorization request an TNFL clinician will review the request and issue a Level.

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

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

CASE SCENARIOS:

When a 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?

Level Assignments

ISSUANCE OF A LEVEL:

Upon receipt of the authorization request a 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

Tertiary, Medically Complex patients are covered by the health plan. Our UM team will assist providers in referring any patients identified as such to the health plan for appropriate authorization and services.

Reimbursement

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). Each payment period is separated into 3 payment Spans: Span 1: Day 1 through day 60; Span 2: Day 61 through day 120; Span 3: Day 121 through day 180.

Span 1: Claims with service dates that occur within Span 1 will be issued as a prorated per diem payment up to the total contracted reimbursement for the assigned impairment-adjusted level based upon the minimum number of service visits outlined in the table below. Once the full impairment-adjusted level payment amount has been issued, no additional payments will be issued in Span 1.

Span 2: A full prospective, impairment-adjusted level payment will be issued on the first claim with a date of service in Span 2 once the minimum number of service visits outlined in the table below are achieved, assuming no other payment has been issued for services in Span 2. If there is no service visit in Span 2, no payment will be made. No payments in Span 2 will be issued as a prorated per diem payment. Only one level payment will be issued in Span 2.

Span 3: A full prospective, impairment-adjusted level payment will be issued on the first claim with a date of service in Span 3 once the minimum number of service visits outlined in the table below are achieved, assuming no other payment has been issued for services in Span 3. If there is no service visit in Span 3, no payment will be made. No payments in Span 3 will be issued as a prorated per diem payment. Only one level payment will be issued in Span 3.

MINIMUM NUMBER OF VISITS REQUIRED FOR EACH SPAN

Level	Impairment Level	Minimum Visits Required for Payments		
		Span 1 (Day 1 – 60)	Span 2 (Day 61 – 120)	Span 3 (Day 121 – 180)
2	Mild	5	6	11
3	Moderate	8	9	17
4	Severe	10	11	21
5	Profound	12	13	25

DISCHARGE FROM CARE UPDATING IMPAIRMENT LEVEL ASSIGNED EPISODES

An Impairment Level may be changed under the following conditions:

- Patient's condition worsens, or treatment plan changes
- Patient is discharged from care after the evaluation is completed and an impairment level is assigned
- During the first 60 days of the episode of care

In either case, the level may be updated to reflect the specific nuances of the episode, and HN1 will reimburse the case based upon the updated level:

- Provider submits Upgrade Form with pertinent clinical notes
- HN1 clinical team reviews form and notes, and if appropriate, changes the level
- HN1 claims department reprocesses impacted claims to issue payment at updated level

PAYMENT OF LEVELS FOR NON-DEVELOPMENTAL DELAY:

After receipt of the first claim encounter after issuance of the level by TNFL the case rate will be paid to the rendering provider. Payment of Levels when Upgrade is Approved for Developmental Delay:

- If at any time during the 180-day treatment period the provider requests an Upgrade and TNFL increases the level assigned, the current level AND all subsequent levels will be paid at the higher level during the 180-day treatment period.
- Upgrades may not be applied retrospectively (after the 180-day treatment period has ended).

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-day treatment period has ended). Payment of Levels when Upgrade is Approved for Non- Developmental Delay: 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 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

CLAIMS PAYMENT ADJUSTMENT:

All Medicaid and Medicare 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.

CLAIM SUBMISSION:

Providers have three ways to submit a claim under TNFL.

1. The preferred method of claim submission is EDI through a clearinghouse. Our Payer ID is 65062 for professional claims and 12k89 for institutional claims
2. The second preferred method is DDE through our provider Web Portal. Providers may use our Web Portal https://asp.healthsystemone.com/hs1providers. Please visit https://therapynetwork.com/pwp to register for an account.
3. If your office is unable to submit claims using a clearinghouse or our provider web portal than you may submit a paper claim on an original CMS 1500 form for professionally billed claims or a UB04 claim form for institutionally billed claims.

   Therapy Network of Florida
   Claims Processing Center
   P.O. Box 350590
   Ft. Lauderdale, FL 33335-0590

Please note: If you submit a claim encounter prior to receiving an approved authorization from TNFL, the claim will deny for no authorization. **Please do not submit your claim until you have an approved authorization on file to cover the dates of services.** In addition, it is very important to submit claims encounters for all dates of service where a patient was treated.

For status of claims, please use our provider web portal. 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). Please visit mytnfl.com to register for an account.

However, if your inquiry requires live interaction then you may call the Provider Claims Customer Services at 877-372-1273. Please listen very carefully to the voice prompts. The voice message may also answer your inquiry without the need for live interaction.

If you have any further questions, please contact our TNFL Provider Relations Department at 1 (888) 550-8800 Option 2, or visit our website at therapynetwork.com/fl.

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 and Medicare 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. In accordance with s. 641.3155, F.S., 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.

Provider Complaints

PROVIDER AND ALL THERAPISTS COMPLAINTS ABOUT NON-CLAIMS: MEDICAID

For provider complaints concerning non-claims issues, HN1 allow providers forty-five (45) days from the date the issue occurred to file a written complaint for issues that are not about claims. HN1 resolves all 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.

Member Information

MEMBER SERVICES

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.

Continuity of Care

MEDICAID

Continuation of Care (COC) period is up to 90 days from the date that the member switched to Aetna Better Health plan. You are not required to obtain an authorization from TNFL/HN1 to continue providing these services during the Continuation of Care Period. If you are NOT a participating provider with HN1/TNFL, 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. 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 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.

HEALTHY KIDS

Continuation of Care (COC) period is up to 90 days from the date that the member switched to Aetna Better Health plan. You are not required to obtain an authorization from TNFL/HN1 to continue providing these services during the Continuation of Care Period. If you are NOT a participating provider with HN1/TNFL, 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. 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 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://trainings.healthnetworkone.com/tnfl. At the end of the training, you will be required to attest that you have completed the training. 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 S. 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

Credentialing

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 many not render services to Conventry (HK/Medicaid) f.k.a Aetna Better Health Medicaid members until they have been fully credentialed.

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. You may not render services to Coventry (HK/ Medicaid) f.k.a Aetna Better Health Medicaid members until the location has been fully credentialed.

PERMANENT LICENSE

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

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.