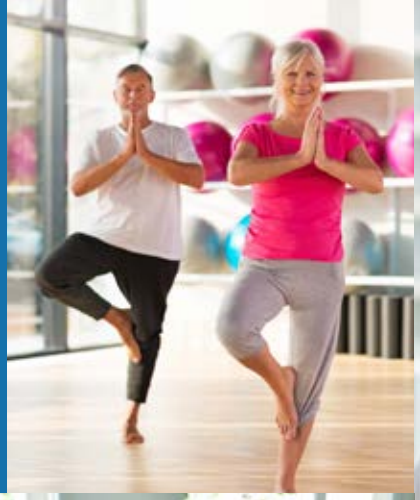

Provider Reference Manual
AvMed Medicare

THERAPY NETWORK OF FLORIDA

AvMed Embrace better health.®

Table of Contents

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 Gomez-Ortiz, M.D.

TNFL, Medical Director

Quick Reference Guide

- Provider relations - 1 (888) 550-8800 Option 2
- Provider relations fax - 305-620-5973
- Authorization - 1 (888) 550-8800 Option 1
- Claims 1 (888) 550-8800 Option 3
- Electronic claims submission (EDI) direct data entry (DDE) through the HS1 web portal, or through a clearinghouse
  Professional Payer ID: 65062
  Institutional Payer ID: 12k89
- Electronic remittance advice (ERA) are provided via clearinghouse.
- Paper claims submission:
  Therapy Network of Florida
  Claims Processing Center
  P.O. Box 350590
  Ft. 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 mytnfl.com/pwp
- Provider web portal link mytnfl.com/hs1webportal

How To Receive Payment For Services

Service Exclusions

Tertiary or medically fragile cases, 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 TNFL. Our UM team will assist providers in referring any patients identified as such to the health plan.

All rendering providers must request a Payment Control Number. You may request a payment control number by submit the following Critical Elements via our Provider Web Portal at mytnfl.com/hs1portal. Fax is available as an emergency backup via TNFL fax at 1-855-410-0121. Forms can be located on our website mytnfl.com.

1. Prescription or Referral Form (N/A for reevaluations)
   - 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 issue a payment control number.

Provider Notification of Payment Control Number

Via the Provider Web Portal at mytnfl.com/hs1portal.

- In addition, TNFL will fax the treating provider an control number indicating the Level.
- Routine requests are completed within 14 days.
- Expedited/Urgent requests are completed within 72 hours.

Requesting a Payment Control Number 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 control numbers via the Provider Web Portal at mytnfl.com/hs1portal/ or via fax to TNFL at 1-855-410-0121.
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 separate payment control numbers for symptoms or conditions associated with the main diagnosis. For example, for a therapy of Status Post Total Knee Replacement, TNFL assigns a payment control number level according to the date of surgery. Concurrent therapy 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 payment control number.

Requesting An Upgrade For A Payment Control Number

- TNFL will only issue a payment control number upgrade 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 payment control number 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

Payment Control Number Level Assignments

Issuance of a Level:

Upon receipt of the control number request a TNFL clinician will review the request and issue a Level based upon the diagnosis, Standardized Test Scores, MCG and clinical record.

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;

Payment Control Number for Custom Splints

All treating providers must submit the Patient Splint form to receive a payment control number. Providers must submit the form via fax to TNFL at 1-855-410-0121. Upon receipt of the Splint form for a payment control number, a TNFL clinician will review the request and issue a Level. Forms can be located on our website mytnfl.com.

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 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?

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.

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

Please note: If you submit an encounter prior to receiving a payment control number from TNFL, the claim will approve and Pay at Zero with the reason code 2343.

- **Reason Code 2343-** Services are approved. Please submit via the Provider Web Portal a copy of the Therapy Prescription, Plan of Care and the Evaluation record so proper payment may be issued.

Payment of Level when a Payment Control Number Upgrade is Approved

- If TNFL issues 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 Level when a Payment Control Number is Issued for a Splint

Reimbursement for Custom Hand Splints will require a control number with a level assignment from TNFL and will be reimbursed according to Exhibit 1 of your Amendment and Plan Addendum.

Claims

The preferred method of claim submission is EDI. Providers may use the HN1/HS1 Web Portal by visiting 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 mytnfl.com to register for an account.

If your office prefers to submit claims electronically via a clearinghouse, 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.

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
Ft. Lauderdale, FL 33335-0590

Please note: If you submit an encounter prior to receiving a payment control number from TNFL, the claim will approve and Pay at Zero with the reason code 2343.

- **Reason Code 2343**- Services are approved. Please submit via the Provider Web Portal a copy of the Therapy Prescription, Plan of Care and the Evaluation record so proper payment may be issued.

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

Claims Payment Adjustment:

All 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 (888) 550-8800 Option 3, 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.

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 the Medicare line of business.

Provider Claim Complaint:

HN1 processes provider complaints concerning claims issues in accordance with s. 641.3155, F.S. HN1 allows providers sixty (60) 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 provides written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

Patient Responsibility

Providers may confirm co-pay, deductible, co-insurance and MOOP details through Availity at www.availity.com.

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.

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 on the AHCA website
- Florida Attorney General's Office: (866) 966-7226

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 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

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

Fraud, Waste, and Abuse and Compliance Training

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 Training

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 desktop 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 going to TNFL's training portal: mytnfl.com/trainings.

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 72 hours of request for therapy services.

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 asha.org/certification/clinical-fellowship.
- Physical Therapists and Speech-Language Pathologists with temporary licenses may enroll as Medicare providers.

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.