Provider Guide
Hillsborough County Health Care Plan
(Hillsborough HealthCare)

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Introduction

Hillsborough County would like to take this opportunity to welcome you to the Provider Network for the Hillsborough County Health Care Plan (HCHCP), also known as Hillsborough HealthCare. We would also like to thank you for your participation and support of the Hillsborough HealthCare’s managed care program, administered by the Hillsborough County Health and Social Services Division (HSS), part of the Department of Family and Aging Services.

Hillsborough County has provided medical care to its indigent (low income) citizens for many years. In the past, funding was based on ad valorem (property tax) monies. As the cost of medical care increased, Hillsborough County sought avenues to continue to provide care with the least monetary impact on its citizens. A Florida Statute was passed which permitted counties to enact an ordinance to levy a sales tax to help fund health care for indigent citizens of Hillsborough County. Hillsborough County first enacted such an ordinance in 1991.

Qualified individuals are those persons "certified by the authorizing county as meeting the definition of the medically poor, defined as persons having insufficient income, resources, and assets to provide the needed medical care without using resources required to meet basic needs for shelter, food, clothing, and personal expenses; or not being eligible for any other state or federal program, or having medical needs that are not covered by any such program; or having insufficient third-party insurance coverage. In all cases the authorizing county is intended to serve as the payer of last resort."¹

Health and Social Services (HSS) has the option to secure medical services from various facilities throughout Hillsborough County in accordance with the Hillsborough HealthCare’s philosophy of providing for the indigent the best possible and most cost effective inpatient care, outpatient treatment, emergency services, and prescribed medications. Hillsborough County is the payer of last resort whenever payment is requested.

When Hillsborough HealthCare administrative protocols and operational procedures change, this Provider Guide will be updated. Updates will include contract and operational changes to the Provider Guide and will include instruction for incorporating them into the Provider Guide. All guidelines for services must be followed in order of date issued for services to be eligible for reimbursement. The effective date of any change will be stated in the updated document. We will endeavor to provide thirty (30) days notice prior to the effective date of the implementation of any major or significant change.

¹ Indigent Care and Trauma Center Surtax, 212.055(4), F.S.
How Hillsborough HealthCare Operates

Hillsborough County contracts with four Medical Service Organizations (MSOs) who manage four provider networks established in the county. Each network includes primary care providers and clinics, sometimes referred to as “Core Services”. Specialists are contracted by the MSOs under a “Specialty Care” arrangement, and hospital-based services are contracted with most hospitals in Hillsborough County. Hillsborough County also contracts with other ancillary service providers, sometimes referred to as “Overlay” providers. Members authorized by HSS to receive services are assigned to a specific medical network and primary care provider (PCP) who manages and monitors the member's care. Services are rendered based on criteria established for the Hillsborough HealthCare and depicted in each of the MSO and Overlay individual contracts, as well as the Hillsborough HealthCare Provider Guide. Participating providers must be Medicaid and Medicare certified providers.

When more than one family member is enrolled in Hillsborough HealthCare, all members of the family (with the exception of those utilizing the Hillsborough County Health Department Specialty Center) are required to utilize the same network for their primary care services. They may utilize specialty care in other networks with prior approval from the Hillsborough HealthCare’s medical management vendor. Members will be provided with a Hillsborough HealthCare identification card with information specific to their type of enrollment.

Eligibility Requirements

Eligibility for Hillsborough HealthCare services is based on the following:

- Residency in Hillsborough County
- Assets within HSS guidelines
- Income at 100% or lower of Federal Poverty Guidelines at the time of enrollment or re-enrollment

Member Co-Payments

Some plans described on the next page require that the members pay a small co-payment for office visits, certain supplies, and at the pharmacy.
Health Care Plans

**Plan A** members are covered for all necessary medical services covered by Hillsborough HealthCare. The member’s primary care provider (PCP) must coordinate all services for these plan members and certain services require referrals and pre-authorization from the medical management vendor.

**Plan J** members are covered for all Plan A services with the exception of inpatient facility charges, which are not covered. Plan J members are enrolled in the Medicaid Medically Needy program.

**Plan B** members are covered for medications and emergent dental services. Specific durable medical equipment and supplies not covered by Medicare may be provided. Plan B members are active Medicare Parts A & B.

**Plan C** members are covered for all Plan A services covered by Hillsborough HealthCare with the exception of inpatient facility charges and home health care as these are covered by Medicare Part A. Plan C members are active Medicare Part A only.

**Plan D** members require specific authorization from Hillsborough HealthCare for each service authorized. Plan D members are covered for only limited & specific services.

**Plan E** members are covered for services under a limited benefit plan which consists of primary care, medications and diagnostic tests only, when ordered by a PCP.

**Plan V** members are veterans who are eligible for services from the Veteran’s Administration. They are covered by Hillsborough HealthCare for emergency room services and emergency hospitalization until sufficiently stabilized for transfer to a Veteran’s Administration Hospital. Plan V members are also eligible for emergent dental services. Veterans must also meet the income requirement of at or below 100% of the Federal Poverty Guidelines to be considered for Plan V services.

**Plan M** is retroactive authorization for payment of specific emergency room services or non-managed inpatient hospital admissions of unfunded members and includes authorization of a follow-up visit up to 30 days after discharge for specialists who rendered non-managed initial care in an inpatient setting. Plan M will not cover hospital facility charges and Plan M does not cover home health care, durable medical equipment, prescriptions or any medical supplies. Once determined eligible for Hillsborough HealthCare, the member is enrolled in the appropriate plan above.
Medical Management

Hillsborough County has contracted with a medical management vendor to provide medical management and utilization review, which includes prior authorization of outpatient services, non-emergent and non-urgent inpatient hospital admissions, and admissions to a skilled nursing facility or assisted living facility with limited nursing service capabilities, and inpatient rehabilitation. The medical management vendor is also contracted to provide case management services and retrospective hospital chart reviews. The medical management vendor provides all authorizations for referrals to specialists, home health care services, supplies, and durable medical equipment. Providers can visit the Hillsborough HealthCare’s medical management vendor’s website at: http://hchcp.keprosouth.com/ for a complete listing of those services requiring prior authorization.

Appointment Availability/Access Standards

Hillsborough HealthCare has certain expectations regarding appointment availability for members within contracted networks. Appointment availability for primary care provider visits should follow the access standards/availability guidelines below:

- Urgent but non-emergent - within 24 hours
- Non-urgent but in need of attention - within one week
- Routine and preventive - within 30 calendar days

Case Management

The medical management vendor’s case management nurses and, in some instances, Hillsborough HealthCare staff nurses, will assist in the management of acute and chronic medical conditions, including catastrophic illnesses, injuries and the planning and management of anticipated medical needs. They will coordinate with primary care providers, specialists, and other health care providers. The medical management vendor’s case management program uses nationally recognized and accepted utilization management criteria, guidelines and protocols.

In all cases, the medical management vendor’s clinical staff and Hillsborough HealthCare staff nurses are available to help providers coordinate and arrange the delivery of covered services in accordance with Hillsborough HealthCare policies and procedures.
The Role of the Primary Care Provider (PCP)

Hillsborough HealthCare is based on the concept of managed care. Care is managed by the primary care provider (PCP), who authorizes referrals to network specialists and arranges for diagnostic tests and other necessary medical services.

Hillsborough HealthCare is committed to ensuring that quality medical care will be made available to all of our members. Hillsborough HealthCare’s goals also include ensuring that all care is medically appropriate and provided in the most cost effective manner.

The primary care model provides a range of preventive health care services. They include regularly scheduled health care services that are age appropriate and assess the general health status of the member. These preventive health care services include:

- Immunizations
- Preventive well care
- Pap smears
- Mammograms
- Vision services (excluding eye exams and eye glasses)
- Hearing Services – Audiology (excluding hearing aids)
- Family planning and counseling can be done at the PCP level or referred to the Health Department
- Screening and management of chronic conditions such as hypertension, diabetes, etc.
- Nutrition counseling
- Preventive diagnostics, e.g. TB screening

The PCP is responsible for coordinating the member’s medical care and will:

- Provide preventive care and routine checkups to help keep the member well
- Provide appropriate treatment when the member is ill
- Order necessary laboratory, x-ray and other routine diagnostic tests
- Order necessary DME, supplies, home health care and oxygen services
- Arrange for the member to see a participating specialist when necessary
Specialty Referrals and Prior Authorizations

In order for a PCP to receive an authorization for referral of a Hillsborough HealthCare member to a network specialist, the PCP **must** request an authorization from the medical management vendor via the internet. The internet address for the medical management vendor is a web-based, HIPAA compliant, Direct Data Entry (DDE) application that enables providers to request referrals or other services and to submit necessary clinical information to support the request.

The authorization issued by the medical management vendor will specify which surgical procedures are authorized, or the type of service, and/or the number of visits that the specialist may see the member.

Specialists should not see any member without a prior authorization from the medical management vendor. Failure to obtain a prior authorization from the medical management vendor will result in the denial of payment. Retroactive authorizations are not provided.

Prior authorization by the medical management vendor is required for selected elective inpatient hospital admissions to determine medically necessary, certain outpatient procedures, all skilled nursing facility admissions, all inpatient rehabilitation admissions, routine stretcher transports, and home health care.

Providers can visit the HCHCP medical management vendor’s website at: [http://hchcp.keprosouth.com/](http://hchcp.keprosouth.com/) for a complete listing of current inpatient and outpatient procedures requiring prior authorization. These services may be periodically updated based on utilization reviews. Prior authorization is not required for emergency admissions or for procedures listed as outpatient when performed in an inpatient setting.

Network Transfers:

Changing PCP assignment is allowed if a member relocates in Hillsborough County or for other justifiable reasons. If the member wishes to change networks, the change is at the discretion of the Health and Social Services Division (HSS). If a change is agreed upon and completed by HSS staff, the requested change is effective the first day of the next month.

It is the member’s responsibility to request and sign a release of medical information to have medical records forwarded to the new PCP. If you have any questions regarding the member’s network designation, please call HSS Customer Service (See Attachment (2) for contact information.)
Covered Services

The services listed below are generally available through Hillsborough HealthCare, but each individual's designated health care “plan” (A, J, B,C, D, E, V, or M) will determine whether a particular service is available and whether a co-payment is applied. Please see Attachment (1) for a list of non-covered services.

Inpatient Hospital Services

Inpatient hospital services include all medically necessary services provided by participating network hospitals for the care and treatment of an inpatient member under the direction of a participating provider.

These services include, but are not limited to, room and board, professional services, medical supplies, diagnostic and therapeutic services, use of hospital facilities, drugs, nursing care, and all equipment necessary to provide the appropriate member care and treatment.

The contracted medical management vendor for Hillsborough HealthCare requires pre-authorization for elective inpatient hospital member admissions.

Skilled Nursing /ALF/Inpatient Rehabilitation

Skilled Nursing Unit services are covered but require pre-certification through the Hillsborough HealthCare’s medical management vendor and are limited to maximum of (45) days per episode of care. Stays in excess of thirty (30) days but no more than forty-five (45) days requires the medical management vendor’s Medical Director approval.

Inpatient member rehabilitation services are covered but require pre-authorization through the Hillsborough HealthCare’s medical management vendor and are limited to maximum of (45) days. Stays in excess of thirty (30) days but no more than forty-five (45) days requires the medical management vendor’s Medical Director approval.
Laboratory Services

Inpatient laboratory services are covered and provided through all network hospitals. Charges are included in the hospital bill. Network contracted outpatient laboratory services require only a prescription from a participating provider. Providers must use a network contracted outpatient laboratory service to be reimbursed.

Outpatient Surgery

Hillsborough HealthCare covers outpatient surgical procedures performed in a participating provider's office, ambulatory surgery center (ASC) or hospital outpatient setting, under the direction of the participating physician.

These services include, but are not limited to, professional services, medical supplies, diagnostic and therapeutic services, use of facilities, drugs, nursing care, and all supplies and equipment necessary to provide appropriate care and treatment.

A surgery/procedure requires a referral from the PCP and a pre-authorization from the medical management vendor prior to performing outpatient surgical services. Providers can visit Hillsborough HealthCare’s medical management vendor’s website at: http://hchcp.keprosouth.com/ for a complete listing of those services requiring prior authorization.
Emergency Room Services

Hillsborough HealthCare covers emergency room services that are provided by an emergency room provider in a participating hospital's emergency room for medical care required to prevent imminent loss of life, irreparable damage, or serious impairment of bodily function, as well as those services that are medically necessary to avoid severe pain and discomfort.

Primary and Specialty Care Services

Primary Care Services

Primary care provider (PCP) services are those health care services that are provided, coordinated, and managed by a provider designated as a Hillsborough HealthCare primary care provider.

Primary care services include periodic medical screening visits, one physical exam every twelve months, family planning, updating of routine immunizations, routine laboratory and radiology testing, vision screening, hearing screening, oral assessment, and health education, as well as referral for further diagnosis, treatment and therapy indicated by the screening process.

Hillsborough HealthCare does allow PCP’s to provide physical exams and complete forms necessary for members seeking employment and/or to obtain licenses/certificates needed for employment.

It is the responsibility of the PCP to perform necessary and basic diagnostic testing for all Hillsborough HealthCare members prior to referring any member to a specialty physician.
Specialty Care Physician/Provider Services

Specialty care physician/provider services are services provided by a participating specialty physician or other authorized network specialty provider, who has been asked to provide a specific service by the member's primary care provider. The specialty physician will report findings and recommendations back to the member's PCP.

There must be a written referral from the primary care provider for outpatient specialist services to be covered. Second opinions within the network are reimbursable if requested by the member and a referral has been obtained from the PCP in advance.

Chiropractic Services

Chiropractic services are a covered service under Hillsborough HealthCare but are limited to three visits annually. A referral from the PCP is required.
Outpatient Diagnostic Services

Outpatient diagnostic services are covered when medically necessary and appropriate, as determined by the medical management vendor. Diagnostic procedures ordered by the member's primary care or specialty physician/provider, and performed in a participating hospital's laboratory or radiology department are covered. Some outpatient diagnostic services require a prior authorization from the medical management vendor prior to services being rendered.

Radiology Services

Radiology services are a covered service. When the service is provided at a network hospital, the charges are included in the hospital inpatient bill or billed separately for outpatient radiology services. If the service is provided at a separate network stand alone facility the provider must bill through the network medical service organization (MSO). Some radiology services require a prior authorization from the medical management vendor prior to services being rendered.
Ambulance Services

Ambulance transportation services are covered for an incapacitated Hillsborough HealthCare member transported to participating hospitals. **Non-emergent transports require pre-authorization from the medical management vendor.** The member may self-refer for emergency services. The member may not self-refer for non-emergent transportation. Members are routinely expected to provide their own private transportation, use public transportation, or the Hillsborough County Sunshine Line (Visit Health and Social Services website at: http://www.hillsboroughcounty.org/hss/socialservices/ for:

- Transportation from home to a hospital day surgery.
- Transportation to a specialty clinic and back home.

Durable Medical Equipment/Supplies

Durable medical equipment (DME) and disposable medical supplies (DMS), including orthotics and prosthetics are covered by Hillsborough HealthCare but must be supported by a prescription and documented medical necessity. Pre-authorization by the medical management vendor is required.
Home Health Care Services

Home health care services are provided for short term, skilled intermittent care in the acute recovery phase of an illness or injury and must follow Medicare guidelines. Pre-authorization is required.

Any member requiring long term services for a chronic illness should be referred to Community Care for the Elderly (CCE) or Community Care for Disabled Adults. HSS does not provide custodial care. Discharge planning is available for Hillsborough HealthCare members at all participating hospitals. The participating hospital will notify the home health agency discharge planning nurse for Hillsborough HealthCare members requiring home health services.

Home Oxygen Services

Oxygen services covered by Hillsborough HealthCare will usually utilize and follow Medicare standards.

IV Therapy

IV therapy is a covered service in inpatient and outpatient settings and is also available through the home health contracted vendor.
Hearing Services – Audiology

Hearing services include necessary hearing examinations, diagnosis, and treatment. Hearing aids and hearing aid repair are not covered by Hillsborough HealthCare.

Dental Services

Hillsborough HealthCare only covers emergency dental procedures to relieve pain and suffering for Hillsborough HealthCare program members.

General Dental Services covered are:

- Limited evaluation of emergency condition
- Radiographs for evaluation/treatment plan of emergency condition
- Treatment to relieve pain and suffering for emergency condition
- Limited coverage is provided for oral surgery to relieve pain and suffering of emergency conditions

Oral surgical procedures and services require a referral from a general dentist and pre-authorization from the medical management vendor.
**Routine Vision Care**

There are no routine vision care services (eye exams and glasses) authorized by Hillsborough HealthCare, except for eye prosthetics. Diabetic and medically indicated eye care is typically covered.

**Mental Health Services**

Mental health services are not generally covered; however, initial evaluation and diagnosis by a psychiatrist and subsequent medication management by a psychiatrist are covered services. Members must be referred by their PCP in order to be eligible for these limited mental health services. Hillsborough HealthCare does not pay for outpatient counseling, residential, inpatient, or long-term mental health therapy.
Pain Management

Acute pain management is defined as 60 days or less in duration for non-surgical events and, for post-surgical events, 90 days or less in duration. Pain Management & all related procedures require a PCP Referral and pre-authorization.

- Coverage is limited to acute injury, dental, and pre- and post-surgical events.
- Coverage is provided for trigger point and Synvisc® injections for clients who have failed a conservative pain management treatment plan.
- Coverage is provided for no greater than two sets of trigger point injections per 12 month period for myofascial pain syndrome.
- Coverage is provided for a maximum of 3 Epidural Steroid Injections in a 12 month period for disc herniation, disc protrusion and Postherpetic Neuralgia only.
- Multilevel transforaminal epidural steroid injection for disc herniation, disc protrusion and Postherpetic Neuralgia only will be treated the same as one level central epidural steroid injection and approved as 1 procedure instead of several different procedures.

Prescription Drug Services

Prescription drug services are for medically necessary and appropriate drugs prescribed by the member's PCP or specialist in accordance with Hillsborough HealthCare’s Formulary.

All prescriptions must be filled through Hillsborough HealthCare contracted pharmacies.

All prescriptions will be filled with GENERIC equivalents unless a generic does not exist.

Pharmacy co-payments may be assessed for all Hillsborough HealthCare members in accordance with Hillsborough HealthCare guidelines.
Pharmaceutical Patient Assistance Program (PAP) /Mail Order Drug Program

Hillsborough HealthCare requires members to participate in the Patient Assistance Program (PAP) for certain brand name medications prescribed by Hillsborough HealthCare participating providers. Hillsborough HealthCare contracts with a PAP vendor to facilitate and provide these services to Hillsborough HealthCare members. All PAP drugs are mailed to the members’ home address and are usually provided as a three month supply. Providers and members are required to participate and assist with processing of the application for medications that qualify for the PAP Program.

Formulary

Hillsborough HealthCare utilizes a closed formulary. An effective formulary system permits the selection of drugs that offer the best balance of clinical effectiveness, safety, cost, and resource utilization. The formulary system is an important component of the overall Hillsborough HealthCare program because it can reduce spiraling drug costs and ensure the highest level of quality in prescription drug utilization.
Emergency Care

The Emergency Medical Treatment and Active Labor Act (EMTALA) definition of emergency care is: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- That there is inadequate time to affect a safe transfer to another hospital
- That the transfer may pose a threat to the health or safety of the individual

The EMTALA is mainly directed towards hospitals that both accept Medicare and advertise emergency room treatment and is designed to protect individuals who visit the emergency room and do not have the means for payment of their care. Such hospitals are statutorily required to provide appropriate screening examinations to determine whether emergency medical conditions exist, regardless of member ability to pay. Where emergency conditions are identified, EMTALA further requires the hospital to stabilize the member.
Public Health Services

The following programs and services are all available to Hillsborough HealthCare members through the Hillsborough County Health Department, an arm of the State of Florida:

Tuberculosis Treatment

Tuberculosis services are available at the Health Department. A referral may be generated if the provider suspects the member may have contracted the disease or if the particular service is not available at their medical site. Members should be referred to the Health Department located at 1105 E. Kennedy Blvd., Tampa. Members may also self-refer for this service.

The Health Department provides all related services once the member tests positive for the disease.

The PCP will continue to provide other health care services not related to tuberculosis.

Sexually Transmitted Diseases

Sexually transmitted disease (STD) services are available at the Health Department. A referral is generated if the provider suspects the member may have contracted an STD or if the particular service is not available at their facility. Members may also self-refer for this service.

The Health Department provides services once the member tests positive for the disease.

The PCP will continue to provide other healthcare services not related to the STD.

Family Planning

Family planning services are available at all Health Department locations except Kennedy Blvd. You may also visit the Florida Department of Health at:

http://www.doh.state.fl.us/

HIV

HIV services are available at the Health Department. Once a member tests positive or the status has previously been confirmed, the PCP should refer the member to the Specialty Care Center at the Health Department for appropriate evaluation.
Professional Services Claims Submission & Timely Filing Requirements

Claims must be submitted and received by the third party administrator from the network Management Service Organization (MSO) within 12 months from the date of service. Payments for claims received after 12 months from the date of service will be denied. Once a claim has been processed, Hillsborough County will release payment to network MSO's. Appeals and adjustments for claims submitted and received within 12 months from the date of service are limited to a period of three months from the date of denial/processing. Providers contracted with their network MSO must submit claims to their contracted network. (Note: If contracted with more than one network, submit the claim based on the member’s assigned network for office visits and place of service network affiliation for hospital services.)

Please note that claims submitted to the MSO must also be appealed to the MSO. The MSO will forward appeals to the third party administrator or Health and Social Services (HSS) if appropriate.

Hospital Facility and Overlay Service Claims Submission

Claims must be submitted and received by the third party administrator within 12 months from the date of service. Claims received by the third party administrator more than 12 months from the date of service will be denied payment. Appeals and adjustments for claims submitted and received within 12 months from the date of service are limited to a period of three months from the date of denial/processing.
Appeals Process

Claims denied or paid incorrectly because of processor error need not be appealed. In such cases, when the provider and third party administrator (TPA) agree an error was made, either verbally or in writing, the provider need only request within 90 days that the TPA reprocess the claim. When a claim is denied payment without TPA error but the provider feels the denial(s) are invalid, the decision to deny payment may be appealed. First and second appeals must be submitted through the network MSO and all appeals must be submitted within three months from the date of denial. First and second appeals are submitted by the MSO, the hospital, or overlay service contracted providers directly to the TPA as described below.

Claims submitted to the TPA for appeal may be due to:

- Improper coding, including unbundling or new CPT / HCPCS codes
- Lack of eligibility (member or provider)
- Non-contracted providers
- Fee schedule issues
- Non-covered services
- Timely filing (MSO supporting documentation is required)
- Require a medical director’s review. (Copy of member’s medical record or relevant medical information must accompany appeal)
- Claims denied for all or some inpatient services
- Appeals that have been denied by the TPA – but must include substantive additional information/evidence that would support reversing the appeal decision made by the TPA

First and second appeals should always be submitted to the TPA via the MSO or directly by the hospital or overlay service provider. Such appeals must be submitted within three months from the date of denial. Claims or appeals should not be directly submitted to HSS unless requested to do so by HSS or it is a request for reconsideration of the second level appeal decision of the TPA.

All appeals are required to be in writing and require supporting documentation including a cover letter explaining the basis of the appeal. Supporting documentation is any information that will help in the decision process when appeals are reviewed, including but not limited to:

- Medical records or daily notes
- Medicare / Medicaid rulings
- Documentation supporting timely filing
• Provider update forms showing effective date as Hillsborough HealthCare provider

The TPA responds to all appeals within a reasonable time, however, the response time for some appeals may be greater than others, such as when extensive research is necessary. To avoid delays or denials, all appeals should have at a minimum, the following required documentation.

• Cover letter
• Copy of the original claim
• Copy of the explanation of payment; or
• Letter of denial from the TPA if one is provided
• Other documentation
  - Medicare / Medicaid denial
  - Other insurance payment / denial

Second level appeals should be submitted directly by the MSO, hospital, overlay provider to the TPA, and must include a letter explaining why the denied appeal should be reconsidered. The second level appeal should include a copy of the original appeal along with the original supporting documentation and the TPA’s response to the first level appeal. In addition, the second level appeal should include supporting information not previously submitted to the TPA that the submitter feels would change the outcome of the appeal.

Providers who wish to appeal the second level appeal decision by the TPA, should provide a letter of request outlining the reasons for the request and send all information with supporting justification to HSS for reconsideration.

Contracted hospital and ancillary/overlay providers who submit claims directly to the TPA should submit first and second appeals following the same guidelines outlined for MSOs. Provider inquiries on the status of appeals are to be made through the network MSO, hospital or overlay provider since the MSO, hospital or overlay provider will be the entity that receives the TPA response in writing - either in the form of payment or a letter of denial.

Appeals for HSS reversals (take-backs) for Medicaid, Medicare, Medically Needy, etc., which are due to payer of last resort requirements should be submitted to the Records and Recovery Section of HSS for consideration.

Provider Reimbursements

MSOs, hospitals, overlay providers and other providers submit electronic claims to the TPA for processing. The claims are processed by the TPA and then sent to Hillsborough County for verification and audit purposes. Once verified the information is placed into the County financial system, and sent to the Hillsborough County Clerk of the Circuit Court for final review and processing of payment. Once processed, the payment is sent to the applicable payee. It should be noted that this process follows the Prompt Payment Act guidelines.
Payment for Unfunded Member

An unfunded member meeting eligibility criteria may be approved for assistance with bills for emergency room and inpatient provider treatment on a retroactive basis. This became effective on June 1, 2005. Hospital facility charges are not covered on a retroactive basis. Hillsborough HealthCare providers who have treated an unfunded member who is subsequently found to be eligible for retroactive assistance by HSS, must submit claims within 12 months of the date the member is found to be eligible for Hillsborough HealthCare. Retroactive hospital services authorizations (AP’s) apply only to hospital emergency room admissions of an unfunded member as approved by HSS.

It is the provider’s responsibility to determine if an unfunded member has been approved for assistance from Hillsborough HealthCare. Eligibility information is available through several means: (1) daily system downloads through the Internet via FTP server; (2) monthly EXCEL files through the Internet via FTP server; (3) call the third party administrator’s customer service; (4) Hillsborough HealthCare’s Interactive Response System (IVRS); and (5) through the vendor screens located on the county’s client information system, referred to as the CLASS system. The contracted hospital or MSO is also available to answer questions. For Internet access through the FTP server, the county contact person can be reached by calling the HSS Customer Service Center number found on Attachment II.

Financial Responsibility

Covered charges reimbursed by Hillsborough HealthCare for eligible members are considered paid in full and may not be balanced billed to the member. In addition, claims denied payment through no fault of the member may not be billed to the member. However, if the member was not active with Hillsborough HealthCare at the time of service and is not eligible for retroactive assistance, normal private pay procedures should apply. Also, if a Hillsborough HealthCare member elects to have a procedure done that is not covered by Hillsborough HealthCare, normal private pay procedures should apply.
Coordination of Benefits / Third Party Liability

Providers are legally and contractually obligated as network providers in Hillsborough HealthCare to seek payment from all identifiable sources. Because Hillsborough HealthCare is a payer of last resort, every effort must be made by providers to obtain reimbursement from other health care programs or plan(s) with which the member may be eligible. Certain diagnoses may qualify a member for presumptive services under other local, state or federal programs. In addition, the member may be subject to subrogation laws or other third party liability payments. In instances of suspected other third party liability, notify Hillsborough HealthCare as soon as possible to expedite filing claims to other payers.

Third Party Recovery

Hillsborough HealthCare initiates recovery on claims paid on behalf of individuals who become eligible for Medicaid, Medicare, Medically Needy (Share of Cost), or other third party payers. It is the policy for Hillsborough HealthCare that all providers be contracted with Medicare and Medicaid to provide services to patients who have Medicaid and Medicare.

- Medicaid

  - When Health and Social Services becomes aware that a client has or may have Medicaid coverage, a Medicaid reimbursement process is initiated by HSS staff. After the client’s Medicaid coverage status has been verified, the recovery process begins.
    - Pharmacies are notified to bill Medicaid for claims paid by Hillsborough HealthCare during the period covered by Medicaid. After 120 days from the date of notification to the provider, the claims are reversed by Hillsborough HealthCare unless the provider submits a Medicaid denial of payment or the drug is an over-the-counter product not covered by Medicaid.
    - Medical providers of primary care, hospital services, specialist provider services, home health care and other overlay providers having claims paid by Hillsborough HealthCare during the period covered by Medicaid are notified to bill Medicaid. After 120 days from the date of notification to the provider, primary care and hospital claims are reversed by Hillsborough HealthCare unless the provider submits a Medicaid denial of payment. Specialist and home
health care claims are reversed upon notification by the provider to Hillsborough HealthCare of Medicaid payment.

- In instances where Hillsborough HealthCare initiates recovery on claims that are over 1 year old and providers cannot bill Medicaid electronically, the provider may file a paper claim can be billed to the Medicaid Area 6 office.

- **Medicare**
  - Medicare claims may be submitted for over one year from date of service, according to Medicare’s time constraints.
  
    - Medical providers of primary care, hospital services, and specialist physician services having claims paid by Hillsborough HealthCare during the period covered by Medicare are notified to bill Medicare. After 120 days from the date of notification to the provider, primary care and hospital claims are reversed by Hillsborough HealthCare unless the provider submits a Medicare denial of payment. Specialist claims are reversed upon notification by the provider to Hillsborough HealthCare of Medicare payment.

- **Medically Needy (Share of Cost)**
  - When a client is eligible for the Medically Needy program, any claims incurred during the remainder of the month after the member has met their share of cost are eligible for payment by Medicaid.

  - Pharmacies receive a list of clients and their date of entitlement for a specific month with instructions to bill Medicaid for all claims incurred from the date of entitlement through the last day of that month. After 120 days from the date of notification to the provider, the claims are reversed by Hillsborough HealthCare unless the provider submits a Medicaid denial of payment or the drug is an over-the-counter product not covered by Medicaid.

  - Medical providers receive a list of claims eligible for payment by Medicaid for a specific month with instructions to bill Medicaid. After 120 days from the date of notification to the provider, the claims are reversed by Hillsborough HealthCare unless the provider submits a Medicaid denial of payment or the drug is an over-the-counter product not covered by Medicaid. Specialist and home health care claims are reversed upon notification by the provider to Hillsborough HealthCare of Medicaid payment.
• Other Third Party Payers

- If a client is found eligible for any other third party coverage, the provider is notified and given available information to facilitate billing of any claims to the third party payer. After 120 days from the date of notification to the provider, the claims are reversed by Hillsborough HealthCare unless the provider submits a denial of payment by the third party payer.

Medicare Fee Schedules

Hillsborough HealthCare utilizes Medicare Fee Schedules. The fees are effective on the effective date of the final published fee schedule or the date notified, whichever is later. These are generally published once a year and sent to the TPA for loading into their system. This does not typically apply to hospital and overlay contracts which may contain negotiated/contracted rates.

Provider Website

Providers should visit the Hillsborough HealthCare Website at: http://www.hillsboroughcounty.org/hss/healthcare/

The Provider Website provides a one-stop shopping experience including:

- Direct links to the TPA and the medical management vendor
- Hillsborough HealthCare Provider Newsletter
- On-line claims status & eligibility verification
- Links to national evidenced based guidelines
- Association sites
- Electronic version of the provider guide
- On-line screening and application processing for members
- Pharmacy formulary
- Pharmacy formulary quick reference wall chart
- And a host of useful information for providers

Customer Service

Providers can also call 272-5040 for customer service and select option 3. They may also verify member eligibility by calling 272-5555.
Attachment (1) - HealthCare Non-covered Services

The following services and supplies are restricted as described or not covered by Hillsborough HealthCare and are not eligible for reimbursement, subject to appeal or requests for pre-determination of services:

Alternative Therapies: acupuncture, aqua therapy, aromatherapy, chelation, music therapy, hypnotherapy, magnet therapy and massage therapy

Bariatric Surgery /weight loss

Bone Stimulators

Cosmetic Services: Non-reconstructive

Custodial Care: care that mainly assists member with bathing, eating, getting in and out of bed, rest cures and domiciliary care. Custodial care does not cover any skilled nursing care

Chronic pain management is defined as greater than 60 days in duration, with the exception of post-surgical events, which may be no greater than 90 days in duration

- Chronic pain management is not covered, except in cases with certain hematologic/oncologic diagnosis/treatment

- No coverage for diagnostic Steroid Injections (SI) and/or Facet Injections, or for injections to evaluate or assess source of pain. Facet injections are occasionally referred to as para-vertebral injections, para-spinal injections and/or median nerve blocks

- No coverage is provided for therapeutic facet or SI joint injections

- No coverage for anesthesia administration for monitored anesthesia care (MAC) for Epidural Steroid Injections or other injection procedures

- No coverage is provided for back surgeries for pain management unless due to acute injury or a significant neurological deficit is present

Dental Treatment: limited to emergencies only to alleviate pain and suffering

Dialysis: outpatient and inpatient if the purpose of admission is for dialysis only

Drug Testing: court ordered

End Stage Renal Disease (ESRD)

Experimental Treatment: services for research studies or charges incurred as a result of complications related to experimental treatments
Furniture: geri-chairs, roll-about chairs, seat-lift chairs, and/or elevator lift chairs for climbing stairs, motorized scooters, and custom made wheelchairs

Hearing Aids

Infertility: testing, treatment, services or supplies related to infertility, artificial insemination, in vitro fertilization and genetic testing

Inpatient Psychiatric Services/Detox

Maternity: any treatment or supplies related to pregnancy or its complications

Non Formulary Medications & Injectables: members are to be referred to PAP vendor; non-formulary medications may be covered in some instances by prior authorization

Personal Comfort Items: items used solely for member comfort not related to an illness or injury. (ex: beds, pillows, meals, diapers, etc.)

Psychological Evaluations: court ordered and/or employment related

Radial Keratotomy: surgical treatment for correction of refractive errors, including radial keratotomy, Lasik, and other such procedures

Reversal of Voluntary Sterilization: services or supplies related to the reversal of a voluntary sterilization

Sexual Reassignment / Dysfunction: services, supplies and/or surgery and any related complications due to sexual reassignment, dysfunction or reversal of sexual reassignment, treatment and testing for impotency, implants of any kind or any related medications

Tempro-Mandibular Joint (TMJ) Treatment: neither passive or surgical treatment

Transplants: any charges for services, supplies, work-ups, treatments, harvesting of organs or organ transplants except corneal transplants

Tuberculosis: treatment for tuberculosis is not covered. Member should be referred to the Hillsborough County Health Department once they have been diagnosed

Vision Services: routine visual acuity exams, eye glasses and contacts are not covered. Treatment by an ophthalmologist for eye disease or injury is generally covered with a referral and pre-authorization

Wound Vacuums

Life Vest – For cardiac stabilization

Insulin Pump
Attachment (2) – Key Hillsborough HealthCare Contact Information

Third Party Administrator (TPA):

Administrative Services, Inc. (ASI)
POC: Gail Demeter
PH: (813) 289-1000 Extension 4510
Fax: (813) 962-1242
Website: www.abpa.com
Customer Service: (813) 962-1960

Medical Management Vendor

KePRO
POC: Karen Curtis, RN
PH: (813) 262-9424
Fax: 1-866-889-6516
Website: http://hchcp.keprosouth.com/
Customer Service: 1-866-495-8388

Health & Social Services

General Manager, Provider & Customer Relations
POC: Gene Earley
PH: (813) 301-7356
Fax: (813) 272-7038
Customer Service: (813) 262-5040